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TTY: 1-800-423-4331

**DATE:** February 7, 2011

**TO:** Interested Parties

**FROM:** Russell Begin, Acting Director, MaineCare Services

**SUBJECT:** Adoption Final Rule: MaineCare Benefits Manual, Chapter I, Section 1, General

Administrative Policies and Procedures

The Department is adopting the following changes to the MaineCare Benefits Manual, Chapter 101, Chapter 1, Section 1, General Administrative Policies and Procedures, to assure that provider requirements align with operation of the Department's new claims system, the Maine Integrated Health Management Solution (MIHMS). Other updates are also included to provide MaineCare Services with internal organizational flexibility and to align the rule with recent federal requirements, including some requirements of the Patient Protection and Affordable Care Act, P.L. 111-148.

- The names of various units and systems within MaineCare Services are changed in order to allow for increased internal organizational flexibility.
- The rule describes how providers submit claims in MIHMS, verify member eligibility and request adjustments to claims.
- Providers have one (1) year from the date services are provided to file a claim correctly with the Department, regardless of when eligibility is verified, except claims for services provided before September 1, 2010 must be filed correctly within one (1) year from the date services are provided or before January 31, 2011, whichever is sooner. Further detail on this deadline is provided regarding retroactive eligibility and when another insurance carrier is involved. This January 31, 2011 deadline was initially adopted by emergency rule on November 16, 2010.
- Section 1.03, Provider Participation, requires that provider license renewals, or proof of application for them, must be received within 30 days prior to the date of expiration or change and providers must update ownership information on an annual basis.
- When an out-of-state provider treats a MaineCare member in an emergency situation, either inpatient or outpatient, resulting in an admission, the provider must contact the MaineCare Office within twenty four (24) hours. Additional Information about DDE (Direct Data Entry), EDT (Electronic Data Interchange) and EFT (Electronic Fund Transfer) is provided.
- Overpayments determined by providers must still be reported to the Department within thirty (30) days of the date of discovery. The rule now requires providers to repay the overpayment to the Department by the later of sixty (60) days of discovery or, if applicable, the time of the relevant cost report. These changes are required by Section 6505 of the Patient Protection and Affordable Care Act, P.L. 111-148 (March 23, 2010).
- Section 1.03-9 recognizes the licensure of advanced practice and registered nurses who have a current, unencumbered compact license from another compact state that they claim as their legal residence.

- Section 1.03-2 provides that MaineCare will not provide payment to any entity outside the United States. This is required by Section 6505 of the Patient Protection and Affordable Care Act, P.L. 111-148 (March 23, 2010).
- Copayment exemptions now extend to services provided in Indian Health Service Centers and services for Native American members who are eligible to receive services funded by Contract Health Services and to members whose monthly copayment sum has totaled 5% of their monthly income. These are required by 42 C.F.R. Part 447.
- The rule also changes the name of Prevention, Health Promotion and Optional Treatment Services to Early and Periodic Screening, Diagnosis and Treatment Services, which are provided pursuant to 42 U.S.C. § 1396d(r).
- Appendix #2 is deleted in order to eliminate obsolete billing codes. Throughout the rule, the Department changes the name of the Office of MaineCare Services to MaineCare Services.

Rules and related rulemaking documents may be reviewed and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider\_rules\_policies.htm. For a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-606-0215.

A copy of the public comments and Department responses can be viewed at and printed from MaineCare Services website or obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-606-0215.

If you have any questions regarding policy, please contact Member Services, 1-800-977-6740 or the Provider Relations specialist assigned to your county. Their phone numbers are available on the internet at http://www.maine.gov/dhhs/oms/provider\_index.html. For TTY: (207) 287-1828 or 1-800-423-4331.

### **Notice of Agency Rulemaking Adoption**

**AGENCY:** Department of Health and Human Services, MaineCare Services

**CHAPTER NUMBER AND TITLE:** MaineCare Benefits Manual, Chapter I, Section 1, General Administrative Policies and Procedures.

#### **ADOPTED RULE NUMBER:**

CONCISE SUMMARY: The Department is adopting numerous changes to the MaineCare Benefits Manual (MBM), Chapter 101, Chapter 1, Section 1, General Administrative Policies and Procedures to assure that provider requirements align with the Department's new claims system and to up-date other aspects of the rule. The methods of claims submission reflect various updates in moving from the Maine Claims Management System (MECMS) to the Maine Integrated Health Management Solution (MIHMS) claims system. Chapter I retains the one (1) year deadlines from dates of services for the correct filing of claims, but adds the proviso that if the service was provided before September 1, 2010, then the claim must be filed within one (1) year or by January 31, 2011, whichever is sooner. Various other changes are made, including requiring that provider license renewals must be received within 30 days prior to the date of expiration or change, that providers must update ownership information on an annual basis and that out-of-state providers treating MaineCare members on an emergency basis must contact the Department within 24 hours. The Department also adopts federally required changes to copayments, including an exemption from copayments for Native Americans (42 C.F.R. § 447.57) and a limit on total copayments to 5% of income (42 C.F.R. § 447.78). The Department adds information regarding filing and managing claims in MIHMS, recognizes nurse licensure to include current, unencumbered compact licenses from another compact state, strengthens the Department's ability to collect overpayments determined by providers (P.L. 111-148, §6506) eliminates obsolete billing codes and pursuant to federal law, eliminates payments to entities outside the United States (P.L. 111-148, §6505). Various grammatical and structural changes are also made to the rule.

**See http://www.maine.gov/dhhs/oms/rules/provider\_rules\_policies.html** for rules and related rulemaking documents.

**EFFECTIVE DATE:** February 13, 2011

**AGENCY CONTACT PERSON:** Michael Dostie, Comprehensive Health Planner

**AGENCY NAME:** DHHS, MaineCare Services

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SECTION 1

# GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# TABLE OF CONTENTS

		I	PAGE 1
1.01	INTRO	DUCTION AND STATUTORY AUTHORITY	1
1.02	MAINE	ECARE ADMINISTRATION	1
	1.02-1	General	1
	1.02-1	Departmental	
	1.02-2	Notice of Agency Rulemaking	
	1.02-3	General Definitions.	
	1.02-5	Department/Provider Notices and Information Dissemination	
1.03	PROVI	DER PARTICIPATION	6
	1.03-1	Enrollment Process for In-State Providers	6
	1.03-2	Enrollment Process for Out-of-State Providers	
	1.03-3	Requirements of Provider Participation	
	1.03-4	Termination of Participation by Provider	
	1.03-5	Confidentiality	
	1.03-6	Requirements for Persons Acting on Behalf of a Provider	
	1.03-7	MaineCare Managed Care	
	1.03-8	Requirements for Agencies Hiring Certified Nursing Assistants (CNAs)	17
Effective 2/13/11	1.03-9	License Verification for Registered Nurses	
1.04	MEMB	ER PARTICIPATION	17
	1.04-1	Additional Eligibility Considerations	10
	1.04-1	(A) Retroactive Eligibility for Services	
Effective		(B) Individuals Residing in Public Institutions	
2/13/11		(C) Undocumented Non-Citizens	
		(D) Individuals Covered Under Dirigo Choice	
		(E) Other Categories	
1.05	SUPPL	EMENTATION BY MEMBERS	19
1.06	COVE	RED AND NON-COVERED SERVICES	20
	1.06-1	Covered Services	20
	1.06-2		
	1.06-3		
	1.06-4	<u>*</u>	
	1.06-5	Non-Covered Services	25
	1.06-6	Broken Appointments	29
1.07	THIRD	PARTY LIABILITY	29
	1.07-1	Definitions Relative to this Section.	29
	1.07-2	Premiums for Enrollment under Group Health Plans	29

SECTION 1

# GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# TABLE OF CONTENTS (cont.)

PAGE 1

	1.07-3	Provider/Department/Member Responsibility Regarding Third Party Liability	y30		
	1.07-4	Implementing Maine State Income Tax Refund Offset	32		
	1.07	(A) Established Debt			
		(B) Administrative Hearing			
		(C) Notification of State Tax Assessor			
		(D) Changes to Notification			
		(E) Administrative Hearing – Tax Offset			
		(F) Finalization of Offset			
	1.07-5	Medicare	33		
	1.07-6 Assignment: Medicare Part B and Companion Plan I Payments				
	1.07-7 Procedures				
1.08	REIME	BURSEMENT	37		
	1.08-1	Maximum Amount	37		
	1.08-2	General Information	38		
1.09	COPAYMENT				
	1.09-1	Copayment Amount			
	1.09-2	Copayment Exemptions			
	1.09-3	Copayment Disputes	39		
1.10	SUBMI	ISSION OF CLAIMS	40		
	1.10-1	Claims			
Effective	1.10-2	Time Limit for Submission of Claims	40		
2/13/11	1.10-3	Methods of Claims Submission	40		
1.11	PAYMENT PROCESS4				
	1.11-1	Payments			
	1.11-2	Rejected Invoices			
	1.11-3	Payments and Denials for all Third Party Payors, Including Medicare	41		
1.12	CLAIN	1 ADJUSTMENTS	42		
Effect.	1.12-1	Underpayments			
Effective	1.12-2	Overpayments			
2/13/11	1.12-3	MaineCare Adjustment Requests	43		

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# TABLE OF CONTENTS (cont.)

		PAGE 2
1.13	INQUIRY PROCESS	
	1.13-1 Unpaid Claims	
	1.13-2 Re-Evaluation of Charges	44
1.14	PRIOR AUTHORIZATION	44
	1.14-1 In-State Services	
	1.14-2 Out-Of-State Services	48
	(A) Procedure and Requirements for Out-Of-State Service	s48
	(B) Exceptions	
	(C) Specific Requirements for Behavioral Health Emerger	
Effective	Mental Health Services for Children	
2/13/11	1.14-3 Early and Periodic Screening, Diagnosis and Treatment Services	
	1.14-4 Medical Necessity	52
1.15	PROVISION OF NECESSARY TRANSPORTATION TO MEDICA	AL SERVICES52
1.16	AUDITS	53
	WENT AND A PROPERTY.	
1.17	UTILIZATION REVIEW	53
	1.17-1 Behavioral Health Managed Care	53
1.18	SURVEILLANCE	53
1.19	SANCTIONS/RECOUPMENTS	
	1.19-1 Grounds for Sanctioning Providers, Individuals, or Entities	54
	1.19-2 Sanction Actions	
	1.19-3 Rules Governing the Imposition and Extent of Sanction	
	1.19-4 Notice of Violation	
	1.19-5 Reinstatement Procedures	61
	1.19-6 Suspension or Withholding of Payments Pending a Final Dete	rmination61
	1.19-7 Procedures Following a Suspension	61
1.20	FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY	62
	1.20-1 Fraud	62
	1.20-2 Statutory Provisions	
1.21	PROVIDER APPEALS	67
	1.21-1 General Principles	
	(A) Administrative Hearing	
	(B) Arbitration Alternative	
	1.21-2 Appeal Options by Type of Facility	69

SECTION 1 GENERAL ADM

# GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# TABLE OF CONTENTS (cont.)

1.22	MEMB	ER APPEALS	PAGE 3	70
	1.22-1		trative Hearing	70
	1.22-2	Notice of Intent t	o Deny, Terminate, Reduce or Suspend MaineCare Eligibility	
			ces	
	1.22-3		uest an Administrative Hearing	
	1.22-4		ninistrative Hearing Requests	
	1.22-5	Corrective Action	1	74
1.23	MAINE	ECARE ADVISOR	CY COMMITTEE	75
	1.23-1	Definitions		75
	1.23-2	Purposes		75
	1.23-3	Members of the 0	Committee	75
	1.23-4	Officers and Sub	committees	77
	1.23-5	Meetings of the O	Committee	78
	1.23-6	Attendance at Co	mmittee Meetings	78
	1.23-7	Staff Support		78
	1.23-8	Powers		79
APP	ENDICES			
Effective		Appendix #1	Code of Ethics for Interpreters	
Effective 2/13/11		Appendix #2	Pertinent Sections for Required Compliance under the Fals Claims Act	e

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.01 INTRODUCTION AND STATUTORY AUTHORITY

The following laws of the United States and the State of Maine provide statutory authority for benefits governed by this MaineCare Benefits Manual (MBM).

- A. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.
- B. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 *et seq.*, 22 M.R.S.A. §3173.
- C. Family Planning Services: 22 M.R.S.A. §1901, et seq.
- D. State Children's Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397.
- E. Cub Care Program: M.R.S.A. §3174-T as enacted by Public Law 1998, Chapter 777, approved by the Governor, April 16, 1998.
- F. Dirigo Health: 24-A M.R.S.A. §6901, et seq.

#### 1.02 MAINECARE ADMINISTRATION

#### 1.02-1 General

The Maine Department of Health and Human Services is responsible for administering MaineCare in compliance with Federal and State statutes, and administrative policies.

#### A. Federal Authority

Federal authority for Medicare, Medicaid, and CHIP rests with the Secretary of the Department of Health and Human Services. Primary responsibility within the Department of Health and Human Services in turn rests with the Centers for Medicare and Medicaid Services (CMS).

### B. State Authority

Authority for the Department of Health and Human Services (DHHS) to accept and administer any funds which may be available from private, local, State, or Federal sources for the provision of the services set forth in this Manual is established by 22 M.R.S.A., §§10, 12 and 3173. The regulations themselves are issued pursuant to authority granted to the Department of Health and Human Services by 22 M.R.S.A. §§42 (1), and 3173.

#### 1.02-2 Departmental

The Commissioner of the Department of Health and Human Services has delegated authority for administering the MaineCare Programs as follows:

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### **1.02 MAINECARE ADMINISTRATION** (cont.)

- A. The Department of Health and Human Services, Office of Integrated Access and Support, determines eligibility for MaineCare.
- B. The Department of Health and Human Services, Program Integrity Unit, Division of Audit monitors the MaineCare Program for fraud, abuse and inefficient use of funds, and also administers sanctions, recovers overpayments and applies penalties.

# Effective 2/13/11

- C. MaineCare Services performs numerous functions related to the delivery of MaineCare Services, including, but not limited to, the following:
  - 1. Clinical and quality management including,
    - a. Prior authorization;
    - b. Classification Review/Case Mix;
    - c. Pharmacy management;
    - d. Provider resource/development;
    - e. Care management, and
    - f. Quality assurance
  - 2. MaineCare operations, including provider and member services, claims research and adjustment, and claims processing;
  - 3. Policy development and revision, including development and revision of MaineCare rules regarding the amount, duration and scope of services and the management of the Medicaid State Plan and related federal waivers;
  - 4. Identifying and collecting reimbursement from legally liable parties for medical expenditures paid by the Department, including estate recovery, casualty recovery, drug rebates, and private health insurance premiums.

Customer Service, including, provider and member services and claims research and adjustments.

Some functions of MaineCare Services may be provided by an agent under contract to the Department.

### 1.02-3 Agency Rulemaking

# Effective 2/13/11

In the event that any requirement of this Chapter I is inconsistent with the requirements of any other Chapter of the MaineCare Benefits Manual, the requirements of this Chapter I shall control.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.02 MAINECARE ADMINISTRATION (cont.)

Effective 2/13/11

The Department publishes a Notice of Agency Rulemaking in the major newspapers to cover the entire State. Copies of proposed rules regarding MaineCare benefits are made available upon request prior to the adoption of any rule, by contacting MaineCare Services, Division of Policy. Copies of all rules, including proposed, emergency and final rules are also available on the MaineCare Services web site at no cost. The address is: http://www.maine.gov/dhhs/oms/rules/provider\_rules\_policies.html. All rules are promulgated in accordance with the provisions outlined in the Maine Administrative Procedures Act and all other applicable statutes and executive orders. Interested parties may also subscribe with MaineCare Services to receive electronic or printed notices and/or copies of all proposed rules for a fee. Members, other State agencies, providers of the particular administrative units, contractors with the administrative unit, public or private non-profit organizations, and agencies or groups representing constituent populations who may be impacted by the printed materials being requested, and selected legislative offices may receive one MaineCare Benefits Manual at no charge upon request. A fee will be charged for additional requests for policies. A sixty-five dollar (\$65.00) fee will be charged for additional requests for the entire MaineCare Benefits Manual (MBM).

The Department must give notice of proposed rulemaking to the following interested parties before a hearing or before the deadline for comments, if no hearing is scheduled:

- A. Any person specified in the statute authorizing the rulemaking;
- B. Any person who, within the past year, has filed a written request with the Agency for notice of rulemaking. The Department may charge a fee reasonably related to the cost of this service; and
- C. Any trade, industry, professional interest group or regional publication that the Department deems effective in reaching affected persons.

### 1.02-4 General Definitions:

- A. **Authorized Agent** means an organization, entity or individual authorized by the Department to perform specified functions pursuant to a signed contract or other approved signed agreement.
- B. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
  - 1. Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child);
  - 2. Serious impairment to bodily functions; or
  - 3. Serious dysfunction of any bodily organ or part.

# SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

### **1.02 MAINECARE ADMINISTRATION** (cont.)

- C. **Emergency Medical Condition for Undocumented Non-Citizens** means a medical condition (including emergency labor and delivery) characterized by sudden onset, and manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - 1. Serious jeopardy to the member's health;
  - 2. Serious impairment to bodily functions; or
  - 3. Serious dysfunction of any bodily organ or part.

MaineCare will not cover any services after stabilization of the emergency condition for undocumented non-citizens. Examples of services that are not considered an emergency medical condition include, but are not limited to: dialysis, organ transplants, school based services, personal care services, waiver services, nursing facility services and hospice services.

- D. **Medical Necessity or Medically Necessary** services are those reasonably necessary medical and remedial services that are:
  - 1. provided in an appropriate setting;
  - 2. recognized as standard medical care, based on national standards for best practices and safe, effective, quality care;
  - 3. required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being;
  - 4. MaineCare covered services (subject to age, eligibility, and coverage restrictions as specified in other Sections of this manual as well as Early and Periodic Screening, Diagnosis and Treatment Services requirements as detailed in Chapter II, Section 94 of this Manual);
  - 5. performed by enrolled providers within their scope of licensure and/or certification; and
  - 6. provided within the regulations of this Manual.
- E. **Member** means any person certified as eligible for services under the MaineCare program.
- F. **Provider** means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity, that

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.02 MAINECARE ADMINISTRATION (cont.)

provides services, goods, supplies, or merchandise, directly or indirectly, to MaineCare members, and that has been enrolled in the MaineCare program.

- 1. Rendering Provider (also known as a Servicing Provider) is defined as an individual MaineCare provider who performs services for eligible MaineCare members through a Group or Facility/Agency/Organization (FAO). A rendering provider does not bill MaineCare directly. The billing provider submits claims and receives payment on behalf of the rendering provider. Throughout these rules, the term "provider" refers to the MaineCare billing provider, unless preceded with "rendering" or "servicing".
- 2. **Billing Provider** means the MaineCare provider submitting claims and receiving MaineCare payment for services. Billing providers perform these functions on behalf of the rendering provider.

### 1.02-5 Department/Provider Notices and Information Dissemination

- A. Unless otherwise specified by statute or regulation the Department may provide notices or disseminate information to the Provider by any of the following methods:
  - 1. in person by a person authorized by MaineCare Services who signs a proof of service.
  - 2. regular U.S. mail, with proper postage, to the address on file with the Provider Enrollment Unit.

# Effective 2/13/11

- 3. certified mail, return receipt, to the last known address.
- 4. facsimile to the number on file with the Provider Enrollment Unit.
- 5. electronic mail to the e-mail address on file with the Provider Enrollment Unit
- B. When sent to the "pay-to" addresses on file with the Provider Enrollment Unit, notices and/or information will be presumed to have been received by the Provider:

- 1. by facsimiles and e-mails, the same day they were sent.
- 2. by regular U.S. mail, the third (3<sup>rd</sup>) day after the notice or information was deposited in the mail.
- 3. by certified mail, return receipt, the date the mail receipt is signed by the Provider, its agent, or employees.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### **1.02 MAINECARE ADMINISTRATION** (cont.)

- C. Except as required by other sections of the MaineCare Benefits Manual, (MBM), notices or information provided to the Department may be sent to the Director, MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine, 04333-0011.
- D. Notices or information dissemination must be provided within the timeframes outlined in the MaineCare Benefits Manual (MBM) and the provider agreement.

#### 1.03 PROVIDER PARTICIPATION

1.03-1 Enrollment Process for In-State Providers

# Effective 2/13/11

A. Providers must complete and return the provider enrollment form and a Provider Agreement in order to enroll as a MaineCare provider. These forms are available by accessing the Department's designated web site at <a href="https://mainecare.maine.gov">https://mainecare.maine.gov</a> for the necessary enrollment forms.

Consistent with 42 CFR §431.107, the Provider understands and agrees that an executed Provider Agreement by and between the Provider and MaineCare is mandatory for participation or continued participation in the MaineCare Program. Updated provider agreements will be required on a regular basis, usually from one to three years. The renewal timeframe will be determined by MaineCare based on other state and federal requirements, whether or not the provider is in-state or out-of-state and other contractual agreements initiated by MaineCare. Providers will be required to update all enrollment information prior to signing the updated agreement. If upon request, a provider fails to timely furnish an executed Provider Agreement to MaineCare, the Provider will be out of compliance. No reimbursement for claims submitted shall be paid to the Provider until compliance is established.

Effective 2/13/11

Providers have a continuing obligation to supply the Department with complete, accurate, and updated information on the Provider Enrollment Form and as required by the MaineCare Benefits Manual and the Provider Agreement. In the event that any requirement of this Chapter governing provider participation is inconsistent with the requirements of any other Chapter of the MaineCare Benefits Manual, the requirements of this Chapter shall control.

- B. MaineCare does not reimburse in-state providers, including rendering providers, for services provided to members prior to enrollment approval.
- C. MaineCare will approve providers for a Provider Agreement or will renew a Provider Agreement only if providers (represented by owners, officers, directors, or persons with controlling interest in the provider) demonstrate that they: 1) meet all relevant licensing and certification requirements; 2) have no debt to the Department or have made acceptable arrangements for payment of that debt; 3) are not currently excluded from participating in MaineCare, Medicare, or any other

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.03 PROVIDER PARTICIPATION (cont)

State or Federal program; 4) are not engaged in any conduct described in Sections 1.19 and 1.20 of this Chapter; and 5) meet all other applicable requirements in Chapters II, III and V of this Manual and all applicable provider agreements and riders. If approved, the provider is enrolled and will receive a National Provider Identification (NPI) or Atypical Provider Identifier (API) plus three-digit service location identifier. These identifying numbers must be used in submitting all claims for payment location identifier.

# Effective 2/13/11

Effective

2/13/11

- D. Once enrollment forms have been completed and returned to the Department, notification of MaineCare's decision will be sent to providers via electronic notification or U.S. mail. The effective enrollment date is the effective date of the provider agreement.
- E. In the case of retroactive enrollment for Federally Qualified Health Centers (FQHCs), the retroactive FQHC enrollment will be effective on the date of the FQHC's Health Resources and Services Administration (HRSA) or Centers for Medicare and Medicaid Services (CMS) approval, not before. In the case of retroactive enrollment for rural health clinics (RHC), retroactive enrollment will be effective on the date of the Medicare approval. In the case of retroactive enrollment for Indian Health Centers (IHCs), the retroactive IHC enrollment will be effective on the date of the HRSA grant.

# Effective 2/13/11

- F. The Department will pay for MaineCare covered services provided only to the following members:
  - 1. Those who are eligible for services on the date the services are actually provided, unless otherwise specified in the MaineCare Benefits Manual; or
  - 2. Those who have been granted retroactive MaineCare eligibility after services have been provided. For more information on retroactive eligibility see Section 1.04-1.

Certain providers will be required to use rendering provider numbers in accordance with the appropriate billing instructions. For some types of new providers not previously reimbursed under MaineCare, reimbursement rates must be established before the provider may be enrolled and reimbursed for covered services. Chapter II outlines additional requirements that may apply in specific instances including State contracts, and certification of State share. Certain providers will be required to: attend provider education sessions; have prior authorization of services; and/or have one hundred (100%) percent review of claims prior to payment.

#### 1.03-2 Enrollment Process for Out-of-State Providers

# Effective 2/13/11

A. All out-of-state providers must be fully enrolled with MaineCare including those providers that provide emergency services. Out-of –state providers can enroll after services have been provided but must do so before billing for the services rendered. The Department may terminate the

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.03 PROVIDER PARTICIPATION (cont.)

enrollment status of an out-of-state provider at any time there are no MaineCare members receiving authorized services from that provider.

Effective 2/13/11

Effective 2/13/11

B. Out-of-state providers who only provide emergency services to MaineCare members traveling out-of-state may bill MaineCare for those services. These providers must notify the Department, or its Authorized Agent, within one business day of an emergency admission for a MaineCare member. Inpatient emergency admissions will be reviewed for medical appropriateness. Length of stay will be authorized by the Department, or its Authorized Agent, and will be based upon medical documentation supporting the member's need for services. In order to be reimbursed by MaineCare for emergency inpatient services provided, the provider must receive and submit an authorization number on the claim form submitted to the Department. For emergency services that do not result in an inpatient admission, the provider must notify the Department, or its Authorized Agent, of the treatment provided to the member, also within one (1) business day. All out-of-state providers must completely fill out all enrollment documents with MaineCare. All enrollment documents can be found on-line at: https://Mainecare.maine.gov In cases where the provider is unable to confirm proof of MaineCare coverage (i.e., member is unconscious, or the member does not have MaineCare card readily available), the provider may exceed the one-day requirement by providing a sufficient explanation of the case.

- C. Other instances in which an out-of-state provider may enroll in MaineCare include, but are not limited to the following:
  - 1. Services and equipment provided to a member who is residing out-of-state, at the discretion of the Department, taking into account cost-effectiveness and medical necessity;
  - 2. A provider who is the sole provider of a type of cost-effective medically necessary item or service may be enrolled only for the purpose of providing that item or service with prior authorization. An example would be an out-of-state laboratory that conducts a test, or a manufacturer of a highly specialized item, not provided by any in-state provider; and
  - 3. An out-of-state provider of services to a MaineCare member who is eligible for services as a Qualified Medicare Beneficiary (QMB) may enroll as a MaineCare provider only for the purpose of billing Medicare coinsurance and deductibles.
- D. The Department reserves the right to issue a request for proposals for provision of any service, pharmaceutical, supply, or piece of equipment. The resulting contract may be awarded to an out-of-state provider.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.03 PROVIDER PARTICIPATION (cont.)

# Effective 2/13/11

- E. Out-of-state providers, within fifteen (15) miles of the Maine/New Hampshire border are treated the same as Maine providers in all aspects of policy requirements, enrollment, rates of reimbursement, and payment methodologies with the exception of out-of-state hospitals, which are excluded from in-state reimbursement methodology as described in Chapter III, Section 45. MaineCare will not provide payment to any entity outside the United States.
- F. Maine-based providers who are providing services out-of-state are considered out-of-state providers and as such are bound by the same requirements as for out-of-state providers, including prior authorization and proper licensure within the state in which services are being provided.

# Effective 2/13/11

### 1.03-3 Requirements of Provider Participation

### Enrolled providers must:

- Effective 2/13/11
- A. Maintain current licenses, as applicable, and must submit a copy of license renewals to the Provider Enrollment Unit to ensure continuity of services through license expiration dates. The Department verifies licenses when possible and notifies those providers that must submit license renewals. Providers must write their NPI and API ID numbers(s) and the three (3) digit service location identifier if applicable on the copy of their license renewals to ensure accurate data entry. License renewals or updates must be submitted to and received by the Department at least thirty (30) days prior to the date of the license expiration or change. If the provider has not received the renewed or updated license in sufficient time, the provider must submit proof of application for the license renewal or update at least thirty (30) days before the license expiration and then provide the license renewal or change with the numbers required above within ten (10) days of receipt.
- B. Notify the Department whenever there is a change in any of the information that the provider previously submitted to the Department. The change may be made on the MaineCare Services portal at <a href="https://mainecare.maine.gov">https://mainecare.maine.gov</a>. Information changes may be submitted manually via mail by obtaining and completing paper forms available only on the MaineCare Services portal listed above. An example would be: a change in address, or the addition or deletion of staff from the practice. This must be done within ten (10) days of each occurrence. Failure to provide complete and accurate information in a timely fashion will constitute good cause for the Department to terminate the agreement.
- C. Not interfere with a member's freedom of choice in seeking medical care from any institution, agency, pharmacy or person who is qualified to perform a required service and is a MaineCare provider.
- D. Not discourage or interfere with a MaineCare member accessing medically necessary MaineCare services for which the member is eligible.
- E. Allow members the freedom to reject medical care and treatment.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.03 PROVIDER PARTICIPATION (cont.)

- F. Provide services and supplies to members in full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the grounds of race, color, or national origin and also without discrimination on the basis of religious beliefs, sex, or handicapping conditions.
- G. Provide services and supplies to members in the same quality and mode of delivery as they are provided to the general public.
- H. Charge and bill MaineCare for the provision of services and supplies to members in an amount not to exceed the provider's usual and customary charges to the general public or, the contractual agreement for a member with a liable third party.
- I. Accept as payment in full the MaineCare rate as specified in Section 1.08-1.
- J. Bill only for covered services and supplies delivered. In cases where services provided include less than a whole unit of a service, the unit shall be rounded up only if equal or greater than fifty per cent (50%) of the unit of service, e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service. The procedure code for the smallest unit of service must be used. Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement.
- K. Accept assignment of Medicare benefits for eligible MaineCare members (as set forth in Section 1.07-5).

Effective 2/13/11

L. Use designated HIPAA compliant billing forms, or accepted 837 transactions, for submission of charges and follow the appropriate MaineCare billing instructions. 837 filings are transactions using the HIPAA standard format for submission of electronic claims. There are three versions of the 837: the Institutional (similar to the UB-40 paper claim); the Professional (comparable to the CMS 1500 paper claim) and the Dental.( comparable to the ADA paper claim).

Effective 2/13/11

M. Maintain and retain contemporaneous financial, provider, and professional records sufficient to fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member. Records must be consistent with the unit of service specified in the applicable policy covering that service. Records must include, but are not limited to all required signatures, treatment plans, progress notes, discharge summaries, date and nature of services, duration of services, titles of persons providing the services, all service/product orders, verification of delivery of service/product quantity, and applicable acquisition cost invoices. Providers must make a notation in the record for each service billed. For example, if a service is billed on a per diem basis the provider must make a notation for each day billed. If a service is billed on a fifteen (15) minute unit basis, a notation for each visit is sufficient.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.03 PROVIDER PARTICIPATION (cont.)

Effective 2/13/11

Records must be kept in chronological order with like information together as appropriate. For MaineCare purposes such records must be retained for a period of not less than five (5) years from the date of service or longer if necessary to meet other statutory requirements. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and a settlement has been made.

Effective 2/13/11

At all reasonable times during the prescribed retention period, persons duly authorized by the Department or the Federal government, whether employees or contractors, shall be given the right to full access to inspect, review, or audit all medical, quality assurance documents, financial, administrative records, and other documents and reports required to be kept under Federal and State laws and regulations. Those duly authorized shall also have the right to obtain copies of such records at no expense to the Department, Federal or State government. The provider and any approved subcontractor shall give the Department or the Federal government complete and private access to the Provider's staff and to any resident or member for the purpose of reviewing the provider's compliance with the provider agreement, and other applicable Federal and State laws and regulations, including laws and regulations governing licensing and certification.

MaineCare providers, and all rendering providers, and any subcontractors, shall make available, during regular business hours, all pertinent provider financial records and all records of the requisite insurance coverage, and all records concerning the provision of health care services to MaineCare members, and all financial records of MaineCare members, to any duly authorized representative of DHHS, the Department's Authorized Agent, the Maine Attorney General's MaineCare Fraud Unit, and the Director of the United States Centers for Medicare and Medicaid Services. MaineCare providers, and all rendering providers, and any subcontractors shall provide, if requested by any of the above, copies of records and documentation, including copies of consolidated financial statements of all related corporations. Failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension from participation in the MaineCare program.

Effective 2/13/11

MaineCare providers, and all rendering providers, and any subcontractors, will make their premises available to any of the above, for announced visits or unannounced visits, for the purpose of determining whether enrollment or continued enrollment in the MaineCare program is warranted, to investigate and prosecute fraud against the MaineCare program, to investigate complaints of abuse and neglect of MaineCare members, and as necessary for the administration of the MaineCare program. Failure to permit inspection by DHHS, the Maine Attorney General's MaineCare Fraud Unit, or the Secretary of the United States Centers for Medicare and Medicaid Services shall be grounds for immediate suspension from participation in the MaineCare program.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

### **1.03 PROVIDER PARTICIPATION** (cont.)

Have safeguards and security measures in place that allow only authorized persons to enter information into electronic records. Passwords or other secure means of authorization must be used that will identify the individual and the date and time of entry. Such identification will be accepted as an electronic "signature." With security measures in place, limited access may be allowed for certain individuals for changes such as member demographic information. There shall be a signature of record on file.

N. Maintain and retain contracts with subcontractors for a period of at least five (5) years after the expiration date of the contract. In addition, records of contractors or subcontractors shall be subject to the same record maintenance and retention rules as are all enrolled providers [refer to Section 1.03-3(M)].

Providers must submit within thirty-five (35) days of the Department's request, full and complete information regarding the ownership of any subcontractor with whom the provider has had business transactions totaling twenty-five thousand dollars (\$25,000.00) or more, during a twelve (12) month period prior to the date of the request. Updates to ownership information will be required on an annual basis.

O. Transfer at no charge clinical records and other pertinent information to other clinicians involved in the member's case, upon request and, when necessary, with the member's signed release of information. Members may only be charged for copies of their own records if the member is requesting that the copies be given directly to them. Charges to the MaineCare member must be in a manner comparable to any charges providers may require from private pay patients.

Enrolled providers must furnish to the Department or its Authorized Agent without charge, in the form and manner requested, pertinent information, including clinical, professional and financial records, regarding services for which charges are made. Where appropriate, as determined by the Department, this will include information necessary to support requests for exemption from managed care requirements and correspondence that substantiates services billed by providers. A release of information signature is not required in order to send records to the Department or its Authorized Agent.

- P. Comply with the requirements of the Department regarding faxed and e-signatures. The Department will accept e-signatures and faxed (facsimile) copies of signatures as evidence of compliance with MaineCare documentation requirements only when the original signature is subsequently forwarded to the Department within (30) calendar days of the date of service or is already on file.
  - 1. Providers must maintain evidence of the faxed and e-signatures in the member's record;
  - 2. A faxed signature by itself without the original signature on record will not be acceptable proof of signature.

Effective 2/13/11

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### **1.03 PROVIDER PARTICIPATION** (cont.)

- Q. Hold confidential, and use for authorized program purposes only, all MaineCare information regarding members. In situations where it is medically necessary for the member's well being, information may be shared between providers. The rules of confidentiality apply to all providers involved as referenced in Section 1.03-5 of this Manual. Confidentiality requirements described in 22 M.R.S.A. Section 1711-C also apply.
- R. Comply with requirements of applicable Federal and State law, and with the provisions of this Manual.

# Effective 2/13/11

Effective

2/13/11

- S. Enter into a MaineCare Provider Agreement with the Department, including any necessary Riders, for example:
  - 1. A Rider is required for school administrative units that wish to request reimbursement for medically necessary covered services included in special education students' Individual Education Plans (IEP) developed by pupil evaluation teams.
  - 2. A Rider is required for institutional providers, such as nursing facilities or hospitals, in order to be reimbursed as such.

# 3. Riders required by separate offices within the Department of Health and Human Services (DHHS) for certain services provided for members related to mental health or mental retardation.

4. Any other Riders as specified in the applicable section of the MaineCare Benefits Manual.

Providers, contractors and intermediaries in public, private or voluntary agencies that have Provider agreements with the Department, are obligated to:

- 1. report any suspected or identified fraud or abuse by providers or members and submit supporting documentation to the Program Integrity Unit, Division of Audit;
- 2. furnish available information, when requested, on excluded individuals and entities requesting reinstatement into the MaineCare Program; and
- 3. ensure that the provisions of 42 CFR 1000, *et seq.*, pertaining to the exclusions of individuals and entities are abided by at all times.

# Effective 2/13/11

T. Disclose to the Department all financial, beneficial, ownership, equity, or other interests of five per cent, (5%) or more, in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to members of medical assistance. This information shall be updated at least annually and upon any change associated with such ownership.

#### 13

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.03 PROVIDER PARTICIPATION (cont.)

Effective
2/13/11

- U. Provide adequate access to medically necessary covered health care services for MaineCare members.
- V. Refer to the Department any evidence demonstrating fraudulent or abusive provider and/or employee practice or overuse of member services by contacting the Program Integrity Unit.
- W. Abide by the provisions of 42 CFR 1000, et seq., pertaining to the exclusions of individuals and entities from participation in Medicare or MaineCare and ensure that excluded individuals or entities are not employed or utilized to provide services, receive payments, or submit claims, to the MaineCare Program. Excluded provider information can be referenced at the Health and Human Services Office of Inspector General web site: <a href="http://exclusions.oig.hhs.gov">http://exclusions.oig.hhs.gov</a> and the Division of Audit, Program Integrity Unit web site: <a href="https://mainecare.maine.gov/mhpviewer.aspx?FID=MEEX">https://mainecare.maine.gov/mhpviewer.aspx?FID=MEEX</a>.
- X. Maintain accurate, auditable and sufficiently detailed financial and statistical records to substantiate cost reports, negotiated rates, by report items, or any other fee for service rate for a period of at least five (5) years following the date of final settlement or established rate with the Department. These records must include, but not be limited to: matters of provider ownership; organization; operation; fiscal and other record-keeping systems; Federal and State income tax information; asset acquisition; lease, sale or other action; cost of ownership information on leased property even if the property is leased from an unrelated party; franchise or management arrangement; patient service charge schedule; matters pertaining to cost of operation; amounts of income received by service and purpose; and flow of funds and working capital.

# Effective 2/13/11

- Y. Attend provider education sessions when required by the Department.
- Z. Submit all claims for review prior to payment, when required by the Department.
- AA. Comply with the requirements of the Federal False Claims Act as referenced in Appendix 2 of this Chapter.
- BB. Comply with this Chapter and all other applicable Chapters and Sections of the MaineCare Benefits Manual.

The Department in accordance with Section 1.19 may sanction providers who fail to comply with these requirements.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.03 PROVIDER PARTICIPATION (cont.)

### 1.03-4 Termination of Participation by Provider or Department

### A. Non-Emergency Termination

Effective 2/13/11

The Department may terminate a provider's participation, or the provider may terminate participation in MaineCare, without cause. The terminating party must send written notification of the termination at least thirty (30) days prior to the effective date of termination. Providers must send this notification to the Operations Director, MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011 Primary care providers must also abide by the termination regulations set forth in the Primary Care Case Management Policy.

# B. Emergency Termination

The Department may terminate MaineCare participation of a provider immediately by giving written notice to the provider if the Department reasonably believes that conditions exist that place the health and safety of members in immediate jeopardy. The provider will be given the opportunity for an informal review after the effective date of the emergency termination. A request for an informal review must be made within seven (7) days of the date of the receipt of the termination notice, or an informal review shall be deemed waived. Any administrative hearing or informal review will be scheduled after the effective termination date and the transfer of members.

# Effective 2/13/11

C. Procedures Following Notice of Termination

Except as otherwise directed by the Department, after notice of termination by either the provider or the Department or after notice of emergency termination, the provider shall:

- 1. Not accept new members for services unless otherwise specifically requested in writing on an individual case basis by the Department.
- 2. In the case of residential providers, undertake appropriate discharge planning and effectuate the transfer of any member who resides in the provider's facility to another contracted provider in an orderly manner consistent with the best interests of the member's health and welfare. Participation cannot be terminated until all members have been placed in an alternative setting and all other legal requirements have been met.
  - 3. In the case of non-residential providers, notify members currently under their care when members present themselves for care, of voluntary termination from the program and arrange for orderly transfer of records to the care of other providers.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# 1.03 PROVIDER PARTICIPATION (cont.)

4. Furnish the Department with access to all information pertaining to each individual member presently being cared for by the provider in such detail as deemed necessary by the Department.

Last Updated: 2/13/11

Effective 2/13/11

The Department shall continue to pay the provider at the same rate as previously allowed consistent with the individual member's classification of care, for a period not to exceed thirty (30) calendar days after the date of receipt by either party of the notice of termination. The Department may decide to continue payment for residential services beyond thirty (30) days during the period of relocation of members.

### 1.03-5 Confidentiality

Providers may disclose information regarding individuals participating in MaineCare only for purposes directly connected with the administration of MaineCare. Providers must maintain the confidentiality of information regarding MaineCare members in accordance with 42 CFR 431, *et seq.* and other applicable sections of State and Federal law and regulations, including compliance with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA).

The Department will ensure that criteria exist specifying the conditions for release and use of information about MaineCare members. Access to information concerning members is restricted to persons or Department representatives who are subject to standards of confidentiality set by the Department.

The Department may not publish or disseminate, in any way, names of members. Permission must be obtained from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of a MaineCare payment.

Parents or guardians of minors may be required to provide annual reauthorization regarding the release of confidential information.

### 1.03-6 Requirements for Persons Acting on Behalf of a Provider

Effective 2/13/11

All persons acting on behalf of a provider, such as employees, agents, volunteers or family members, are bound by and must adhere to MaineCare rules and regulations. Violations committed by any of the above named parties may result in sanction actions as defined in Section 1.19-2 of this Manual.

# 1.03-7 MaineCare Managed Care

Effective 2/13/11

MaineCare managed care providers are primary care providers when all parties have completed and signed a MaineCare provider Agreement and have received approval from MaineCare to provide comprehensive health care to members receiving managed care benefits. Such providers must comply with Chapter VI, Section 1, Primary Care Case Management and other appropriate sections of the MaineCare Benefits Manual.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### **1.03 PROVIDER PARTICIPATION** (cont.)

# Effective 2/13/11

Unauthorized use of a primary care provider's NPI identification number by any provider will be deemed to be fraud and may result in the sanctions described in Section 1.19 of this Chapter.

1.03-8 Requirements for Agencies Hiring Certified Nursing Assistants (CNAs)

Providers that hire certified nursing assistants and are reimbursed by MaineCare are required to check with the Maine Registry of Certified Nursing Assistants and to comply with all requirements as stipulated in the Department of Health and Human Services Rules and Regulations Governing the Functioning of the Maine Registry of Certified Nursing Assistants, Chapter 128.

# Effective 2/13/11

1.03-9 License Verification for Registered Nurses

Providers shall verify that all registered nurses they hire or employ are currently and validly licensed as a registered professional nurse by the Maine State Board of Nursing or hold a current, unencumbered compact license from another compact state that they claim as their legal residence.

#### 1.04 MEMBER PARTICIPATION

The Office of Integrated Access and Support defines a member as a person determined to be financially eligible in accordance with the eligibility standards published by that Office in the MaineCare Eligibility Manual.

The MaineCare Eligibility Manual is published and maintained by the Office of Integrated Access and Support. Detailed information regarding financial eligibility standards can be obtained by contacting the Regional Offices of the Department of Health and Human Services. If there are any conflicts or inconsistencies between financial eligibility guidelines described in this Manual, and the MaineCare Eligibility Manual, the MaineCare Eligibility Manual governs.

Members are also subject to eligibility requirements to determine need for specific services as detailed in other Chapters and Sections of this Manual. The Department may reassess a member's medical eligibility at any time. Pursuant to 42 CFR §435.916, if the Department has information about anticipated changes in a member's circumstances, the Department must re-determine eligibility at the appropriate time based on those changes.

# Effective 2/13/11

The Department issues an identification card to all members. Providers must verify an individual's eligibility for MaineCare prior to providing services. Eligibility may be verified by point of service systems and web-based systems available to providers. MaineCare eligibility verification can also be checked by calling the Department's Interactive Voice Response System. Providers who do not have access to a touch-tone telephone may contact Provider Services as described in Section 1.13.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

### 1.04 MEMBER PARTICIPATION (cont.)

Verification of financial eligibility does not assure reimbursement if any requirements for medical eligibility and prior authorization have not been met.

The Department reserves the right to change the frequency of card issuance; to provide separate cards for members restricted to seeing certain providers (See Chapter IV of the MaineCare Benefits Manual); and to change the card format and content.

# 1.04-1 Additional Eligibility Considerations

# A. Retroactive Eligibility for Services

The following retroactive reimbursement procedure does not apply to situations where a person has knowingly misrepresented his or her status to a provider as a MaineCare applicant or member.

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In some cases, financial eligibility for medical services may be determined retroactively. If covered services were provided during a period of retroactive eligibility, and if the member made any payment toward those retroactively-covered services, the provider, if requested to do so by the member within nine (9) months of the date of the original written notification of MaineCare eligibility, must reimburse the member the full amount paid by the member within fourteen (14) days of being notified by the member.

The provider may then bill MaineCare for those same services. Failure to reimburse the member will result in sanctions as defined in Section 1.19. In cases where MaineCare eligibility is determined after a service is provided, the provider has one year from the date the eligibility was granted to file a claim correctly with the Department, except that if eligibility was granted before September 1, 2010, the provider must file a claim correctly within one (1) year from the date eligibility is granted or by January 31, 2011, whichever is sooner.

### B. Individuals Residing in Public Institutions

- 1. For inmates involuntarily confined in a public institution, State or Federal prison, jail, detention facility or other penal facility, who are MaineCare members, MaineCare will pay only for their covered inpatient medical institution services provided to the inmate while an inpatient in a hospital, nursing home, intermediate care facility for the mentally retarded (ICF-MR), or juvenile psychiatric facility. MaineCare will not pay for any other services.
- 2. MaineCare will pay for all MaineCare coverable services for individuals admitted to and residing in an Institution for Mental Diseases (IMD) for over thirty (30) days, if the individual is under twenty-one (21) years of age or age

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79 Last Updated: 2/13/11

### **1.04 MEMBER PARTICIPATION** (cont.)

sixty-five (65) and over. MaineCare will not cover the cost of services for individuals who are age twenty-one (21) and over and under sixty-five (65) years of age while residing in an IMD.

### C. Undocumented Non-Citizens

MaineCare coverage for emergency services for undocumented non-citizens extends only to those services necessary to stabilize the emergency condition.

MaineCare does not cover any further treatment or rehabilitation resulting from the emergency even though such treatment may be necessary. Please refer to Chapter I, Section 1.02-4 (C) of this Manual for the complete definition of emergency services for undocumented non-citizens.

# D. Individuals Covered Under Dirigo Choice

Payment for services will be made for members who are enrolled through their employer under the Dirigo Choice Plan and MaineCare. MaineCare members will receive two medical cards, one from Dirigo Choice and one from MaineCare.

Services not covered by Dirigo Choice (wrap services) may be billed to MaineCare. All claims billed to MaineCare must be for covered services. Members must follow all requirements from Dirigo Choice to assure that the plan provides maximum coverage. [24-A, M.R.S.A. §6911.]

### E. Other Changes

The Office of Integrated Access and Support may establish other categories in accordance with the MaineCare Eligibility Manual. These special categories define or limit the particular services a person may be eligible to receive. For example, in the category of "Qualified Medical Beneficiary (QMB) eligible only," MaineCare covers only the Medicare coinsurance and deductible. If Medicare does not allow the service, the member is responsible.

#### 1.05 SUPPLEMENTATION BY MEMBERS

MaineCare providers must accept the allowances for covered services established by the Department as payment in full. Providers must also comply with State and Federal law as well as the provisions of the MaineCare Benefits Manual, Chapter I, Section 1.03-3.

Providers who request or require supplementary payment for MaineCare covered services are in violation of MaineCare rules and are subject to administrative sanctions. Private supplementary payment includes, but is not limited to, charging fees for referrals to other providers or consultants, charging a fee to request prior authorization, or charging fees for any other administrative services required in the process of providing MaineCare services.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

#### 1.05 SUPPLEMENTATION BY MEMBERS (cont)

Title 42 U.S.C. §1320a-7(b) specifically provides, in part, for criminal penalties as follows:

"Whoever knowingly and willfully; (1) charges, for any services provided to a patient under a State Plan approved under subchapter XIX of this title, money or other consideration at a rate in excess of the rates established by the State shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars \$25,000 or imprisoned for not more than five (5) years, or both."

Payment may be made by the Department only for MaineCare covered services provided to individuals who are eligible for services on the date the services are actually provided unless otherwise specified in the MaineCare Benefits Manual, or who have been granted retroactive MaineCare eligibility after services have been provided.

Members may not be charged for covered services provided during any period of eligibility unless a member has knowingly misrepresented, in writing, his or her MaineCare status. Enrolled providers must bill the Department for covered services provided to a member during any period of eligibility for which the provider expects to be reimbursed. Nothing in this paragraph shall be construed as prohibiting a provider from providing free care.

### 1.06 COVERED AND NON-COVERED SERVICES

#### 1.06-1 Covered Services

All covered services reimbursable by MaineCare must be medically necessary and described in the MaineCare Benefits Manual. MaineCare members are eligible for as many covered services that are medically necessary and within the limitations outlined in applicable sections of this Manual. The Department reserves the right to require additional medical opinions or evaluations by appropriate professionals of its choice concerning medical necessity or expected therapeutic benefit of any requested service.

Covered services include those services described in other Chapters of this Manual and other medically necessary health care, diagnostic services, treatment, and other measures, as required by the Omnibus Reconciliation Act of 1989. These services are intended to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services described in the Manual sections applicable to Early and Periodic Screening, Diagnosis and Treatment Services for members under age twenty-one (21); whether or not such services are (otherwise) covered under the Medicaid State Plan as long as they would otherwise be federally allowable under the State Plan.

Effective 2/13/11

#### 1.06-2 Telehealth

A. Telehealth is defined as interactive, visual, real-time telecommunication.

Telehealth must be a medically appropriate means of provider-patient interaction.

1. Services provided via telehealth must utilize equipment that is capable of two-way video and audio (i.e., telephone, facsimile interactions and electronic mail delivered services are not reimbursable).

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont)

- 2. There must be a compelling benefit for the member in order for telehealth services to be appropriate. The benefit must be related to physical, social or geographic issues that make delivering the service in person difficult. It must not be for the convenience of the provider. The member's record must contain documentation that the member has met one or more of the criteria listed below:
  - a. Physical: A member's medical condition makes a face-to-face encounter that entails significant travel inadvisable or impossible.
  - b. Social: The family or other support system does not support a member traveling a distance for a face-to-face encounter, or does not allow the member to take the time that travel will require.
  - c. Geographic: There is a lack of medical/psychiatric/mental health expertise locally, limited transportation resources, or a long wait for such local care.
- 3. Providers who want to provide and bill for services via telehealth must submit a specific description of the telehealth services and must be enrolled as a provider of the service that they wish to provide via telehealth. They may not be reimbursed for services provided via telehealth until they have received approval from the Department to do so.
- 4. MaineCare reimburses for services delivered via telehealth by approved MaineCare providers only when those services are defined in the MaineCare Benefits Manual as a covered service.

### B. Provider Responsibilities

When requesting approval to provide services via telehealth, providers must submit the following information to MaineCare:

- 1. The names, provider numbers and licensure level of individual providers who utilize telehealth to provide services;
- 2. A list of the procedure codes that will be utilized;
- 3. A statement explaining the rationale for needing telehealth capabilities for the service(s) being proposed;
- 4. A statement explaining the specific criteria utilized in determining when telehealth services are more appropriate than face-to-face services;
- 5. A plan for quality assurance activities specifically related to patient satisfaction and outcomes related to telehealth service; and

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

- 6. Educational information that will be provided to the MaineCare member at the time of the member's visit. This information should be written at a sixth grade comprehension level and at a minimum it should include the following information:
  - a. Description of the telehealth equipment and what to expect;
  - b. Explanation that the use of telehealth for this service is voluntary and that the same service is available in a face-to-face setting;
  - c. Explanation that the member is able to stop the telehealth visit at any time and request a face-to-face service;
  - d. Explanation that MaineCare will pay for transportation to a distant appointment if needed and;
  - e. HIPAA compliance information regarding the telehealth encounter.
- 7. Any additional information determined by the Department as necessary to protect members and ensure the integrity of the program. Documentation must be sent to the Medical Director MaineCare Services, 11 State House Station, Augusta, ME 04333-0011. MaineCare Services will review this justification and, if in agreement, will send the provider a letter of approval that must be kept on file.

### C. Reimbursement for Telehealth

- 1. MaineCare does not reimburse for any charge related to the technical aspect of the telehealth service or for personnel at the originating or receiving site, nor may a member be billed for such charge.
- 2. MaineCare will not reimburse for the use or upgrade of technology, transmission charges, and any charges for an attendant who instructs a patient or caretaker in the use of the equipment or supervises/monitors a patient during the telehealth encounter, or for consultations between professionals.
- 3. Providers must not bill for portions of a physical exam not actually performed by the rendering provider unless it is possible to actually confirm the finding via the telehealth equipment (i.e., visually or via auscultatory equipment of appropriate sensitivity).
- 4. Reimbursement for telehealth is limited to those services already being provided by that provider in compliance with the MaineCare Benefits Manual.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79 Last Updated: 2/13/11

# COVERED AND NON-COVERED SERVICES (cont.)

- 5. Services are to be billed in accordance with applicable sections of the MaineCare Benefits Manual. Providers must submit claims in accordance with Department billing instructions. The same procedure codes and rates apply as for services delivered in person.
- 6. The GT (Interactive Telecommunication) modifier must be used when billing for services provided via telehealth.

#### D. Documentation

- 1. Services delivered via telehealth are held to the same standard of documentation as non-telehealth services.
- 2. Each instance of telehealth service will require documentation as to why telehealth was utilized to deliver that service.

### 1.06-3 Interpreter Services

1.06

- A. Providers must ensure that MaineCare members are able to communicate effectively with them regarding their medical needs. MaineCare will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary and reasonable to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered MaineCare service or medically necessary follow-up visit(s) to the initial covered service. Interpreter travel time is covered but wait time is not.
- B. Family members or personal friends may be used as interpreters, but cannot be paid. "Family" means any of the following: husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.

Family members or friends, with the exception of those individuals under the age of 18, may be used as non-paid interpreters if:

- 1. requested by the member; and
- 2. the use of this friend or family member does not compromise the effectiveness of services or violate the member's confidentiality; and
- 3. the member is advised that an interpreter is available at no charge to the member.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

- C. If a paid interpreter is hired, providers can select the interpreter. However, should the interpreter provide transportation to the member, MaineCare will not reimburse the interpreter for transporting the member while concurrently billing for interpreter services. All interpreter services must be provided in accordance with the Americans with Disabilities Act.
- D. When providers request reimbursement for any interpreter services, the services must be included in the member record. Documentation must include a statement verifying the interpreter qualifications, date, time and duration of service, language used, the name of the interpreter, and the cost of performing the service.
- E. Providers are responsible for ensuring that interpreters protect patient confidentiality and adhere to an interpreter code of ethics. Providers shall document that interpreters have provided evidence of having read and signed a code of ethics for interpreters equivalent to the model included as Appendix #1. This shall be deemed as compliance with this requirement.

### F. Interpreter Codes

Providers must use the following code when billing for reimbursement for interpreters for both deaf/hard of hearing members, and for language interpreters required for non-English speaking members:

T1013 Sign language or oral interpreter services per fifteen minutes.

The actual billable amount should not exceed the customary charge of the interpreter.

G. Interpreters for Deaf/Hard of Hearing Member

Providers of interpreter services must be licensed by the Maine Department of Professional and Financial Regulation as: Certified Interpreters/Transliterators, Certified Deaf Interpreters, Limited Interpreters/Transliterators, or as Limited Deaf Interpreters.

MaineCare will pay for two interpreters for deaf MaineCare members who utilize non-standard signing and request a relay interpreting team including a deaf interpreter, for whom signing is in his/her native language, working with a hearing interpreter.

Note: Any other codes for interpreter services for deaf/hard of hearing members currently listed in the specific service sections of the MaineCare Benefits Manual are no longer valid.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

### H. Language Interpreters

Providers may obtain language interpreter services either through local resources, national language interpreter services such as the "Pacific Interpreters, Language Line," or comparable services. Wherever feasible, local and more cost effective interpreter resources are to be used.

In all cases, the provider must include in the member's record the date and time of the interpreter service, duration, language used and the name of the interpreter. For language interpreters required for non-English speaking members, providers must use:

T1013GT

Interpreter services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service, must be by report with copies of the invoice attached.

# I. Exceptions

Hospitals, private non-medical institutions, intermediate care facilities for people with mental retardation, and nursing facilities may not bill separately for either language or deaf/hard of hearing interpreter services. For hospitals, private non-medical institutions, ICF-MRs, and nursing facilities, these costs will be allowable and are included in the calculation of reimbursement.

J. The Department will not pay for interpreter services when there is a primary third party payor if the primary third party payor is required to cover the interpreter services.

### 1.06-4 Presumptive Eligibility for Services for Pregnant Women

- A. Presumptive eligibility can only be determined by qualified providers. The term "qualified provider" is defined in 42 USC 1396r-1. Examples of qualified providers to determine eligibility are: Federally Qualified Health Centers; Indian Health Centers; Rural Health Clinics; Family Planning Agencies; WIC Agencies.
- B. Pregnancy-related services are those services that are necessary for the health of the pregnant woman or fetus, or that have become necessary as a result of the woman having been pregnant.

### 1.06-5 Non-Covered Services

A. MaineCare will not reimburse for non-covered services. Providers may bill members for non-covered services only if, prior to the provision of the service, the provider has clearly explained to the member that MaineCare does not cover the service and that the member will be responsible for the payment. Providers must

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

document in the member's record that the member was told, prior to provision, that the service was not a MaineCare covered service and that the member is responsible for the payment.

B. The following services are considered non-covered services. Costs for these non-covered services are not reimbursable by MaineCare, or by the member unless the notification requirements described in Section 1.06-4(A) have been met.

MaineCare does not reimburse for:

- 1. services not described in the MaineCare Benefits Manual, or related Principles of Reimbursement;
- 2 experimental procedures or drugs not approved by the Food and Drug Administration (FDA);
- 3. services that are primarily custodial care, respite care, socialization, academic, religious, vocational, or educational, unless specifically permitted elsewhere in this manual including:
  - a. Custodial Services

Custodial Services are any services, or components of services, of which the basic nature is to provide custodial care.

b. Socialization or Recreational Services

Socialization or recreational services are any services, or components of services, of which the basic nature is to provide opportunities for socialization, or those activities that are solely recreational in nature. These non-covered services include, but are not limited to picnics, dances, ball games, parties, field trips, and social clubs.

c. Academic/Educational Services

Any services or components of service provided to members that are academic or educational in nature. Academic services include, but are not limited to, those traditional subjects such as science, history, literature, foreign languages, and mathematics.

d. Vocational Services

Vocational services include organized programs such as vocational skills training, or sheltered employment, that prepare individuals for paid or unpaid employment.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

4. services that have prerequisites that have not been met as defined in the appropriate section of the MaineCare Benefits Manual, including prior authorization and medical eligibility requirements;

Last Updated: 2/13/11

- 5. any items or services that have been purchased elsewhere that are required to be purchased through a volume purchase agreement between the State and a provider;
- 6. services provided without a pre-admission screening and/or concurrent review as required by the Department;
- 7. services provided by a psychiatric facility, institution for mental diseases, or institutional service provided for members age twenty-one (21) to sixty-five (65). No Federal financial participation is available for these services or this population; and
- 8. any other services not provided in conformance with the requirements of this Manual.
- C. Coverage Limitations Associated with Managed Care

MaineCare will not cover the cost of services denied by a managed care plan when the service was denied because the member did not comply with the plan's requirements. When a member receives services not in compliance with the managed care plan, the member is responsible for paying for those services. Examples of member non-compliance include but are not limited to, failure to obtain the necessary referral from the managed care plan, or receiving services from a provider who does not participate in the managed care plan. This applies both to MaineCare managed care benefits and private managed care plans. There is an exception for members with emergency medical conditions that are screened, stabilized, and transferred as required by federal law.

Providers of MaineCare Managed Care services, as noted in Chapter VI Primary Care Case Management, must have a referral from the member's primary care provider site prior to the member visit. Certain services are exempt from needing a referral from the primary care provider and are outlined under Chapter VI, Section 1, Primary Care Case Management, Section 1.05.

- D. Request for Rule Change or New Rules for MaineCare Coverage of Non-Covered Services
  - 1. When a member or provider requests authorization for MaineCare coverage of a service not currently covered by MaineCare, that request will be denied (see exception in Section E, for members with Early and Periodic Screening, Diagnosis and Treatment Services). The individual or group making the request may contact MaineCare Services, Director, Division of Policy, to request a formal review of a proposed new service. Appropriate staff will then review the request.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

- 2. MaineCare Services will consider, but is not obligated to cover, health interventions within the specified service sections if they meet all of the following outcome criteria:
  - a. the intervention is for a medical condition;
  - b. there is sufficient evidence to draw conclusions about the effects of the intervention on health outcomes:
  - c. the evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;
  - d. the intervention's expected beneficial effects on health outcomes outweigh its expected harmful effects; and
  - e. the intervention is the most cost-effective method available to address the medical condition.
- 3. Key definitions to support the above statements are:
  - a. Medical Condition: is a disease, an illness, or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness, or injury.
  - b. Health Outcomes: are outcomes of medical conditions that directly affect the length or quality of a person's life.
  - c. Sufficient Evidence: is considered to be sufficient to draw conclusions if it is peer reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.
  - d. Health Intervention: is an activity undertaken for the primary purpose of preventing, improving, or stabilizing a medical condition. Activities that are not considered health interventions include those that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner.
  - e. Cost: an intervention is considered cost effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost.
- E. As described in Section 1.14, the Department shall take all reasonable and necessary steps to ensure that all requests for prior authorization of services for

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

### 1.06 COVERED AND NON-COVERED SERVICES (cont.)

Effective 2/13/11

MaineCare members receiving Early and Periodic Screening, Diagnosis and Treatment Services that are determined to be non-covered under this Manual, shall be considered for coverage under Early and Periodic Screening, Diagnosis and Treatment Services, prior to being denied as non-covered.

### 1.06-6 Broken Appointments

Providers may not bill members for broken appointments, even if providers advised members prior to the service.

#### 1.07 THIRD PARTY LIABILITY

#### 1.07-1 Definitions Relative to this Section

#### A. Insurer is:

- 1. any commercial insurance company offering health or casualty insurance to individuals or groups including both experience-rated insurance contracts and indemnity contracts; or
- 2. any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of any injury, disease, or disability; or
- any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.
- B. Third Party is any individual, entity, benefit or program, excluding MaineCare, that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member as described in Section 1.07-3.

# Effective 2/13/11

C. Early and Periodic Screening, Diagnosis and Treatment Services.

### 1.07-2 Premiums for Enrollment under Group Health Plans

As a result of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, Section 4402), covered services include MaineCare payment of group health plan premiums when a member's enrollment under a group health plan is cost-effective. MaineCare considers a premium payment cost-effective when the costs of a member's MaineCare services are likely to be greater than the cost of paying the premium for a member to receive care under the group health plan.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### 1.07 THIRD PARTY LIABILITY

The Division of Third Party Liability of MaineCare Services determines cost-effectiveness and follows guidelines approved by the Centers for Medicare and Medicaid Services.

Last Updated: 2/13/11

1.07-3 Provider/Department/Member Responsibility Regarding Third Party Liability

- A. State and Federal rules and regulations determine the Department's liability for payment of claims submitted to MaineCare for services provided to individuals enrolled in a health maintenance organization or managed care plan or those who have other available third party resources.
- B. MaineCare is the payer of last resort. The only exception is for services involving Indian Health Services (IHS) claims. IHS is the payer of last resort for Native Americans enrolled in MaineCare.
- C. If a claim has been denied by a member's third party payor for services deemed as not medically necessary, the provider must appeal the decision of the third party payor before billing MaineCare. If the appeal results are unfavorable, the provider must submit the original denial, the appeal results and a completed claim form to MaineCare for evaluation.
- D. The Department recognizes extenuating circumstances where services covered by third party payers:
  - 1. may not be geographically accessible; or
  - 2. members are not given the opportunity to directly choose a provider that participates in the member's primary insurance. This may occur, for example, when the provider is involved in the member's care to interpret test or radiological results or to administer anesthesia; or
  - 3. good cause has been established pursuant to 42 CFR §433.147.

The Department will reimburse for services for which the member would otherwise be eligible in instances where these extenuating circumstances exist. The Department shall have total discretion to adopt standards for the above circumstances for members covered by third party insurers.

Effective 2/13/11

A member may request an extenuating circumstance exception in writing to the Director MaineCare Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011. If the member's request for extenuating circumstances is denied, the Department shall provide written notice to the member of the member's right to an administrative hearing.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.07 THIRD PARTY LIABILITY (cont)

Effective 2/13/11

- E. The provider must establish whether the member has third party resources available for payment of the rendered service. Third party resources may include, but not be limited to, private or group insurance benefits, participation in a health maintenance organization (HMO), Workers' Compensation, Medicare or other potentially liable insurers and responsible parties. For all questions involving the determination of coverage by a third party insurer, providers may contact MaineCare Services, the Division of Third Party Liability, directly to verify health insurance information.
- F. The provider must take all necessary and reasonable measures within the provider's ability to receive payment from such resources prior to billing MaineCare. Payment by the primary HMO to non-participating providers does not obligate MaineCare to pay as a secondary payer. This applies even if the primary HMO authorizes the service. If the provider will not be eligible to receive MaineCare reimbursement as a result of failing to participate in the member's plan, the member must be notified in writing that he or she will be billed. This must be done prior to providing the service and documented in the member's record. The following exceptions apply:
  - 1. when a claim is for prenatal services (see Appendix #2 for services that the Department will pay and then seek reimbursement from the liable third party);
  - 2. when a claim is for Early and Periodic Screening, Diagnosis and Treatment Services and
  - 3. when the third party liability has not yet been established (litigation).
- G. In cases where third party payment responsibility is questionable or unavailable, providers are responsible for billing the Department for covered services within the one year time frame described in Section 1.10 of this Chapter.
- H. The Department will take reasonable measures to ascertain any legal liability of third parties for medical care and services rendered to members, the need for which arises out of injury, disease or disability. With the exception of those services described in this sub-section, MaineCare is not liable for payment of services when denied or paid at a rate reduced by a liable third party payor, including Medicare, because the services were not authorized, or a non-participating provider provided services that were coverable under the plan.
- I. The Department is not responsible for payment of services inappropriately obtained (including self referrals which result in reduced payments) by a member enrolled with any liable third party payor including Medicare or for making additional payments to providers who offer discounts to (or who agree to accept reduced payments from) third party payers.

# Effective 2/13/11

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

#### **1.07** THIRD PARTY LIABILITY (cont)

- J. The Department is not liable for payment of services provided to MaineCare members enrolled with a liable third party payor, including Medicare, when services have not been authorized prior to provision and/or approved by the member's primary care physician when required.
- K. The Department is responsible for payment of a copayment, deductible or coinsurance required by a third party payer when services have been appropriately obtained under MaineCare. Such payments shall be limited to the maximum amount designated by the Department for covered services, in accordance with Section 1.07-7(B) and (C).
- L. The Department shall also be responsible for payment of covered services provided outside an eligible individual's liable third party payor including Medicare, in situations where providers available to the individual under the plan were geographically unavailable (i.e., out-of-state policyholder).
- M. The member must do whatever his or her primary health plan requires assuring that the plan provides maximum coverage for the services. This includes, but is not limited to, seeing a geographically accessible participating provider, seeking referrals from his or her primary care provider where indicated, utilizing network providers, obtaining prior authorization when required, or other actions as appropriate. If the member fails to do what is necessary to maximize benefits from these primary payors, MaineCare will not reimburse the provider for the service and the member will be responsible for payment.

# 1.07-4 Implementing Maine State Income Tax Refund Offset

The Department will seek reimbursement from a third party when the party's liability is established after assistance is granted and in any other case in which the liability of a third party existed but was not treated as a resource.

Submission to the Maine State Tax Assessor for State income tax refund offset may be utilized to recover money from an individual or entity that is due the Department.

#### A. Established Debt

- 1. When implementing a Maine State Income Tax Refund Offset, the Department will notify the individual or entity of the alleged debt and his or her right to an administrative hearing.
- 2. If the individual or entity fails to request a hearing within sixty (60) calendar days of the date of the receipt of the notice alleging the debt, the individual or entity is deemed to have forfeited the right to an administrative hearing and waived any objection he or she may have to this debt, and the Department will implement a Maine State Income Tax Refund Offset. The debt shall be deemed paid only to the extent of the amount received by the Department.

# SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# THIRD PARTY LIABILITY (cont)

1.07

# B. Administrative Hearing

If an administrative hearing is requested within sixty (60) calendar days of the date of the receipt of the notice alleging the debt, a hearing shall be held pursuant to the Maine Administrative Hearings Regulations. In determining if a debt is established, the hearing shall be limited to the issues of whether the money is due the Department. If a hearing was held and the alleged debt owed to the Department was affirmed by the hearing decision, the Department will implement a Maine State Income Tax Refund Offset. The offset shall be applied and the debt shall be deemed paid only to the extent of the amount received by the Department.

#### C. Notification of State Tax Assessor

The Department shall notify the State Tax Assessor annually of all individuals or entities who owe a debt to the Department that is greater than twenty-five dollars (\$25.00).

### D. Changes to the Notification

The Department shall notify the State Tax Assessor of any decrease in or elimination of past due debt which has been submitted for effective collection by State Income Tax Refund Offset.

# E. Administrative Hearing-Tax Offset

Pursuant to 36 M.R.S.A. §5276-A (2), before a tax offset may be made, the State Tax Assessor will provide notice to the debtor of the intended tax offset and of the debtor's right to request that hearing. Upon such timely request, an administrative hearing shall be held pursuant to 5 M.R.S.A. §8001, *et. seq.* and the Maine Administrative Hearings Regulations. These hearings shall be limited to the issues of whether the debt is collectable and whether any post collection events have affected the debt.

#### F. Finalization of Offset

If the debtor fails to make a timely request for a hearing or a hearing is held before the Department and a collectable debt is determined to be due the Department, the offset is final except as determined by further appeal. The Department must release to the taxpayer any offset refund amount determined after a hearing not to be a debt due to the agency within ninety (90) calendar days of such determination or as otherwise provided by the creditor agency in a promulgated rule.

#### 1.07-5 Medicare

Medicare, authorized by Title XVIII of the Social Security Act, provides health insurance for most individuals' age sixty-five (65) and over, and for others who meet specified disability requirements. Medicare benefits include hospital insurance and related care (Part A) and supplemental medical insurance (Part B). MaineCare complements and supplements the

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.07 THIRD PARTY LIABILITY (cont)

Medicare Program, subject to Section 1.07-5 (C). Each person eligible for Medicare (Part A and/or Part B) is issued a red, white and blue Social Security Health Insurance Card showing the beneficiary claim number, Medicare coverage and effective date.

In order to receive MaineCare reimbursement, providers must accept assignment (unless specifically noted in other Chapters of this Manual) of Medicare Part B for services to MaineCare members for whom coinsurance/insurance and deductible may be payable. All providers delivering services reimbursable by Medicare must participate in Medicare in order to receive MaineCare reimbursement.

Providers must indicate acceptance of this assignment by checking the appropriate box on the Medicare invoice. Coinsurance and deductible charges for Medicare covered services are to be made to the Department only after adjudication of the claim by the Medicare Intermediary or carrier. In determining the Department's liability for the Medicare Part B deductible and coinsurance the following shall hold:

A. Federally qualified health centers, rural health centers, physicians, psychologists, Advanced Practice Registered Nurses, ambulance providers, mental health clinics, ambulatory care clinics, QMB providers, podiatrists, and optometrists may bill MaineCare for Medicare coinsurance and deductible. The total payment from both Medicare and MaineCare cannot exceed the lowest rate that Medicare determines to be the allowed amount.

#### B. Indian Health Centers

Indian Health Centers providing services under ambulatory care clinics are eligible for the all-inclusive rate published in the most recent federal register.

#### C. All Other Medicare Part B Services

- 1. For claims received from January 1, 1997 until February 29, 2000 the total payment from both Medicare and MaineCare cannot exceed the lowest rate allowable by Medicare; and
- 2. For all other providers for claims received on or after March 1, 2000, (except for psychologists, for whom the effective date is April 1, 2001, and podiatrists for whom the effective date is September 21, 2001, and optometrists for whom the effective date is July 1, 2002) the total payment to the provider from both Medicare and MaineCare cannot exceed the lower of the Medicare approved amount or the maximum allowance established by the Department for services provided, in cases where assignment is required. In cases where assignment is not required (as described in Chapter II, Section 60, Medical Supplies and Durable Medical Equipment, of the MaineCare Benefits Manual), payment will not exceed the maximum allowance established by the Department for the services provided.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.07 THIRD PARTY LIABILITY (cont)

1.07-6 Assignment: Medicare Part B and Companion Plan I Payments

MaineCare is not liable for payment of any charges for services provided to dually eligible (MaineCare/Medicare) members that exceed the approved amount by Medicare Part A, Part B unless specifically noted in other Chapters and for Companion Plan I collectively. MaineCare's liability is limited to the lowest amounts listed in Section 1.07-7(C).

#### 1.07-7 Procedures

#### A. All providers must:

- 1. take all necessary and reasonable measures within the provider's ability to receive payment from any third party resource (accept assignment, enrollment, participation), also available to their eligible patients, before billing MaineCare with the exception of those services described in Section 1.07-3;
- 2. identify third party resources and total third party payments on the MaineCare claim;
- 3. wait ninety (90) calendar days from the date of service for a MaineCare member or policyholder to cooperate with respect to third party resources. If after ninety (90) calendar days the member or policyholder has failed to cooperate, MaineCare may then be billed, according to appropriate billing instructions available from the Department.

MaineCare does not reimburse providers who inappropriately provide services to MaineCare members enrolled in a health maintenance organization or managed care plan who do not participate in the HMO or managed care plan, or where services must be authorized prior to provision by the member's primary care provider.

Cooperative policyholder(s) and/or members include:

- a. those who provide necessary third party insurance information to providers when requested to do so;
- b. those for whom providers are able to obtain necessary signatures required to process third party claims; and
- c. those who have been reimbursed by a third party, and have then reimbursed the provider for the services for which they received the reimbursement. The Department will not reimburse in any situation where the member or policyholder received third party payment because the provider did not accept assignment and/or was not enrolled.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.07 THIRD PARTY LIABILITY (cont)

- 4. show evidence of third party resource responses (explanation of benefits, including explanation of the basis for denials, and related information) prior to billing MaineCare for covered services. Claims that include such evidence may only be billed to the Department as instructed, according to the appropriate billing instructions.
- 5. bill MaineCare without having received payment or denial notice from the third party in cases where insurance is provided by an absent parent of a member. Providers must first bill the third party. If no answer is received within thirty (30) calendar days of the date of service, providers may then bill MaineCare.

Providers must certify they have billed the insurer and have not received a response. Certification must be submitted on the provider's office letterhead. For proper certification wording and the Department's follow-up plans, please see the following:

Proper Certifica	tion Wording:
I certify that I ha	ave submitted the attached claim to
<u></u>	(health insurance company name).
I have waited thi	rty (30) calendar days. I have received no response
I understand the these certificatio	Department will audit provider compliance with n requirements.
_	(Signature)
_	(Date)

6. ensure that any time a MaineCare bill (copy) or an itemized hospital bill is given to a MaineCare member, attorney or insurance company, the following must be stated on the copy: "MaineCare Member Benefits

Assigned to the State of Maine by Law."

B. Payments to Hospitals

MaineCare payment for hospital services is based upon rules established by the Department of Health and Human Services that are in effect for dates of service, less payment obligated or made by any third party. When a third party payment is available, MaineCare will pay only the difference between the amount of the third party payment and the MaineCare allowed amount.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### **1.07** THIRD PARTY LIABILITY (cont)

C. Individual Providers Balance Billing After Third Party Payment

When billing MaineCare after receiving a third party payment, individual providers must follow these procedures:

#### 1. Fee-for-Service Claims

- a. Charges must equal the allowed amount as agreed to with the particular insurance carrier as determined from the Explanation of Benefits (EOB).
- b. The third party amount must equal the actual third party payment plus any withheld amount as indicated on the insurance company's Explanation of Benefits.

#### 2. Capitated Services

Charges must equal the copay amount when balance billing for capitated services. Capitated services should be billed with the charges equal to the copay amount. Capitated services are services covered under the monthly capitation payment agreement between a managed care plan and the member's provider.

#### 1.08 REIMBURSEMENT

#### 1.08-1 Maximum Amount

Unless specified in other Chapters of this Manual, the maximum amount of payment for services rendered shall be the lowest of the following:

- A. the MaineCare rate of reimbursement as found in the applicable Chapter of the MaineCare Benefits Manual or as published by the Department;
- B. the lowest amount allowed by Medicare Part B;
- C. the usual and customary charges;
- D. the amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set forth in Section 1.07-7. A claim is considered paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

It is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.08 REIMBURSEMENT (cont)

#### 1.08-2 General Information

- A. MaineCare members, family members or guardians do not have the authority to prohibit a provider from billing for a MaineCare covered service.
- B. MaineCare will only reimburse enrolled providers for MaineCare covered services.

  Under no circumstance can MaineCare reimburse MaineCare members.

#### 1.09 COPAYMENT

A copayment will be charged to each MaineCare member each time certain MaineCare services are provided if stipulated in the Chapter and Section of this Manual covering those services. If a section does not specify that copays be charged, no MaineCare copayment is collected from MaineCare members for services provided under that section. If a copayment is required, the exact amount of the copayment shall be as specified in the MaineCare Benefits Manual that covers the specific service provided.

#### 1.09-1 Copayment Amount

This section supplements the copayment information included in all sections of Chapter II of the MaineCare Benefits Manual, except in those sections where additional provisions are specifically noted.

- A. The member shall be responsible for copayments up to the limit per month specified in the section of Chapter II covering the particular service, whether the copayment has been paid or not. The limit may vary, depending upon the service type. After the monthly cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.
- B. No provider may deny services to a member for failure to pay a copayment unless otherwise stipulated in other sections of this Manual. Providers must rely upon the member's representation that he or she does not have the money available to pay the copayment. A member's inability to pay a copayment does not relieve him/her of liability for a copayment.
- C. Providers are responsible for documenting the amount of copayments charged to each member regardless of whether the member has made payment.

#### 1.09-2 Copayment Exemptions

No copayment may be imposed with respect to the following services:

- A. Family planning services and supplies;
- B. Services furnished to members under twenty-one (21) years of age;

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

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# 1.09 COPAYMENT (cont)

- C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF-MR, or other medical institution, or a resident of a private non-medical institution, if that individual is determined by the Department to be responsible, as a condition of receiving services in that institution, to have an "assessment" or a "cost of care." Cost of care is defined in the MaineCare Eligibility Manual and is not waived or affected by any of these exemptions;
- D. Services furnished to pregnant women, including services provided during the three months following the end of a pregnancy;
- E. Members in State custody;

# Effective 2/13/11

- F. Services provided in Indian Health Service Centers and services for Native American members who are eligible to receive services funded by Contract Health Services.
- G. Members under State guardianship;
- H. Hospice Services
- I. Emergency services as defined in Chapter I, Section 1.02.4 (B) of this Manual;

# Effective 2/13/11

- J. Member's whose monthly copayment sum has totaled 5% of their monthly income.
- K. Any additional exceptions listed in specific sections of Chapter II of this Manual.

# Effective 2/13/11

- L. Providers are responsible for verifying copayment responsibility by calling Provider Services or other means made available by the Department.
- M. For billing instructions for copayment exemptions, see the specific section in Chapter II of the MaineCare Benefits Manual under which services are provided.

# 1.09-3 Copayment Disputes

Effective 2/13/11

Providers must notify members of their right to dispute copayments. If a member believes that he or she is exempt from a copayment, disputes the amount of the copayment, or has been denied a service for failure to make a copayment, he or she may contact the Department for assistance in resolving that dispute. Complaints should be directed to the Director, MaineCare Services, 11 State House Station, Augusta, Maine 04333-0011.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.10 SUBMISSION OF CLAIMS

#### 1.10-1 Claims

# Effective 2/13/11

Charges to the Department for services provided under MaineCare are to be submitted only on original claims approved by MaineCare Services, or in the electronic format approved by MaineCare Services. The MaineCare Services' web site contains information pertaining to billing instructions.

# 1.10-2 Time Limits for Submission of Claims

# Effective 2/13/11

The following time limits apply unless waived under special circumstances by the Department. Providers have one (1) year from the date services are provided to file a claim correctly with the Department, regardless of when eligibility is verified, except claims for services provided before September 1, 2010 must be filed correctly within one (1) year from the date services are provided or by January 31, 2011, whichever is sooner. Since it is the responsibility of providers to verify eligibility, members may not be billed for covered services that have been denied by the Department for exceeding this time limit for claims submission because the provider did not verify eligibility. The time limit in this paragraph may be exceeded only as follows:

# Effective 2/13/11

# Effective 2/13/11

- A. If eligibility for MaineCare is determined after a service is provided, providers have one (1) year from the date that MaineCare eligibility was granted to bill the Department, except that if eligibility was granted before September 1, 2010, the provider must file the claim correctly within one (1) year of the date eligibility was granted or by January 31, 2011, whichever is sooner.
- B. In cases involving other insurance carriers or Workers' Compensation, claims must be filed correctly within one year from the date on the carrier's explanation of benefits, except if the explanation of benefits occurred before September 1, 2010, the provider must file the claim correctly within one (1) year of the date of the explanation of benefits or by January 31, 2011, whichever is sooner.

#### 1.10-3 Methods of Claim Submission

#### A. Original Paper Claims

It is extremely important and necessary that all paper claims be accurate, complete and legible. Only typed original claims or computer generated original claims with information clearly entered within the required information fields are acceptable for processing. All attachments must be eight and one-half by eleven inch (8½x11) paper. Providers must follow billing instructions issued by the Department. All claims are computer processed, and any mistakes may substantially delay processing. All claims must be signed and dated by the provider, or by an employee so authorized by the provider. Computer generated authorization or a stamped signature is also acceptable.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### 1.10 SUBMISSION OF CLAIMS (cont)

The provider must assume full responsibility for the accuracy of the invoice even when submitted by the provider's office. Any claim lacking clear authorization will be rejected (refer to Section 1.11-2) without payment.

Last Updated: 2/13/11

# Effective 2/13/11

#### B. Direct Data Entry (DDE)

Providers may submit claims directly into the claims processing system via a HIPAA- compliant web portal using Direct Data Entry (DDE). When DDE is used, providers will have the ability to identify and correct certain errors at the time the claim is entered, notwithstanding other provisions of this Chapter. Providers can obtain access to this portal at <a href="https://mainecare.maine.gov/Default.aspx">https://mainecare.maine.gov/Default.aspx</a>

# C. Electronic Data Interchange (EDI)

Providers may submit claims using an 837 HIPAA format for submission of electronic claims. Refer to both the Implementation Guide and Companion Guide for MaineCare-specific submittal instructions at <a href="https://mainecare.maine.gov/ProviderHomePage.aspx">https://mainecare.maine.gov/ProviderHomePage.aspx</a>

#### 1.11 PAYMENT PROCESS

#### 1.11-1 Payments

# Effective 2/13/11

The Office of the State Treasurer issues all payments. A Remittance Advice (RA) is generated with each payment showing the payment or denial of specific claims. Providers who are registered Trading Partners may download the RA from their Trading Partner account and will also receive an 835. Payment will be made by Electronic Fund Transfer (EFT), unless the provider is unable to accept payment in this manner. In those cases the Office of the State Treasurer shall provide an alternative method of payment....

#### 1.11-2 Rejected Invoices

# Effective 2/13/11

If the claim is rejected due to invalid or incomplete information, no reimbursement is made. Rejected claims will be identified either during the claim submission process or on the RA and will include a reason for the rejection. A correct claim must be resubmitted within the time limits previously stated in Section 1.10-2 before payment will be considered.

If a covered service was denied payment, or an incorrect amount was paid due to a billing or processing error, providers must follow appropriate billing instructions issued by the Department (see Section 1.12).

#### 1.11-3 Payments and Denials for all Third Party Payors, Including Medicare

Providers shall bill the appropriate third party payor, including Medicare, for those MaineCare members also covered by the third party payor. Providers are to comply with the most current billing instructions as made available by the Department.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### 1.12 CLAIM ADJUSTMENTS

Under certain circumstances, an adjustment may be made on the billing claim form or on electronically filed claims to reverse or to reverse and replace a claim. Providers must comply with the most current billing instructions issued by the Department.

Last Updated: 2/13/11

# 1.12-1 Underpayments

When, as the result of an audit, the Department determines that an underpayment has been made to a provider, the Department will notify the provider and send written authorization allowing the provider to bill MaineCare.

Effective 2/13/11

If a provider believes an underpayment has been made for covered services rendered, based upon policy and procedures as described in this Manual, the provider should accept and cash the check issued for the services provided. The provider must request a review of payments, using the MaineCare Adjustment Request form, within one hundred and twenty (120) days of the remittance statement date or waive any right to a review of that payment. MaineCare Adjustment Request forms are available at

https://mainecare.maine.gov/Provider%20Forms/Forms/Publication1.aspx?RootFolder=%2fProvider%20Forms%2fClaims&FolderCTID=&View=%7b55EF7D29%2d59ED%2d4CC1%2dA015%2d69037A886B14%7d

# 1.12-2 Overpayments

An overpayment from MaineCare may indicate that a provider has submitted bills and/or received payment to which he or she is not properly entitled.

- A. When, as a result of an audit, review or other information, the Department determines that it has overpaid a provider, the Department will notify the provider, in writing, as to the nature of the discrepancy, the method of computing the reasonable dollar amount to be refunded and of any further action.
- B. Provider Determination of Overpayment. When a provider determines that an overpayment has been made, the provider shall comply with the most recent reimbursement instructions issued by the Department. Overpayments must be reported to the Department within thirty (30) days of identification and repaid in accordance with Title XI, § 1128J(d) of the Social Security Act within sixty (60) days or by the date any corresponding cost report, if applicable, is due, whichever is later. Failure to reimburse the Department for an overpayment may result in provider sanctions, as detailed in the Social Security Act, Title XI, § 1128J(d). These sanctions are described in Section 1.19.
- C. The Department or its Authorized Agent may recover overpayments made to a provider through direct reimbursement, offset, civil action or other actions authorized by law, pursuant to Title 22, M.R.S.A., Section 1714-A, including interest on overpayments.

# Effective 2/13/11

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79 Last Updated: 2/13/11

# 1.12 CLAIM ADJUSTMENTS (cont.)

#### 1. Direct Reimbursement

Unless other regulations apply, the provider must reimburse the Department within thirty (30) calendar days of the date of the notice of the overpayment.

#### 2. Offset

The Department may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when overpayments are not repaid as required in Section 1.12-2(C)(1) in accordance with State and Federal rules and regulations.

#### Civil Action

The Department may file a civil action in the appropriate Court and exercise all other civil remedies available to the Department in order to recover the amount of an overpayment.

#### Liens and Foreclosure

Pursuant to 22 M.R.S.A. §1714-A the Department may recover the amount of an established debt through lien and foreclosure thirty-one (31) calendar days after exhaustion of all administrative appeals and any judicial reviews under 5 M.R.S.A. §8001 *et seq*.

#### 1.12-3 MaineCare Adjustment Request

# Effective 2/13/11

Providers shall submit adjustment requests, which require review by MaineCare Services, on a MaineCare Adjustment Request form with appropriate documentation and a new claim form.

Some examples for use of this form are: the provider is requesting additional funds on a previously paid claim, an original claim was denied as a duplicate, medical necessity/medical review is required, and Prior Authorization is required. Providers have one hundred twenty (120) days from the date of the remittance statement to submit the MaineCare Adjustment Request form.

#### 1.13 INQUIRY PROCESS

There are two options available to providers to check member eligibility, co-pay information, claim status, third party payment insurance, and eligibility for MaineCare managed care benefits. These options are a web based system and an Interactive Voice Response System. These options are available twenty-four (24) hours a day, seven (7) days a week and allow unlimited inquiries providers will be required to furnish. The MaineCare provider ID number, the member's name, date of birth, and the member's ID number or Social Security Number will be needed before any information can be given. Providers should attempt to resolve questions via the web based system or the Interactive Voice Response System, or other means made available by the Department, prior to calling the Provider Services Unit.

SECTION 1

# GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# Last Updated: 2/13/11

#### 1.13 INQUIRY PROCESS (cont)

# Effective 2/13/11

When a provider is in need of an immediate resolution to a policy and/or procedural question, the Provider Relations Unit may be contacted by telephone, or by submitting an e-mail inquiry.

Written inquiries regarding the payment or nonpayment of claims should be mailed or faxed to:

Provider Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011

Priority will be given to written inquiries that contain copies of claims, Remittance Advices and any other pertinent documents, because these documents expedite issue resolution.

#### 1.13-1 Unpaid Claims

# Effective 2/13/11

When a provider does not receive information regarding the payment of a specific claim from the Department, he or she may use the Web-based System or call the Interactive Voice Response System, or use other means made available by the Department, regarding the status of the claim before rebilling. The web based system and Voice Response System will let the provider know if the claim has been paid or denied and on what date. If there is no information on file, it means the claim was not received and should be resubmitted.

#### 1.13-2 Re-evaluation of Charges

If a provider questions the payment he or she has received for a service, a written inquiry must be made within one hundred and twenty (120) calendar days from the date of the Remittance Advice. The provider must comply with the most current procedures made available by the Department.

#### 1.14 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain services. The PA requirement is spelled out in each section of other Chapters of this Manual whenever it applies to a covered service. In addition, management of high cost member services and/or supplies may require PA by the Department or its Authorized Agent.

#### 1.14-1 In-State Services

Effective 2/13/11

A. The dated and signed request for prior authorization must be made by the member's provider in writing and sent to the MaineCare Prior Authorization Unit, or as appropriate, to the Department's Authorized Agent or any other office as required by the Department and provided in other sections of this manual. For prior authorization contact information and where to send completed prior authorization forms visit the MaineCare Services website at: https://mainecare.maine.gov

A request for prior authorization must be signed by the provider and must include:

1. Member's name and MaineCare identification number;

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### **1.14 PRIOR AUTHORIZATION** (cont.)

- 2. Diagnosis for which the request is being made;
- 3. The procedure(s) requested and its/their corresponding code(s);
- 4. Date(s) of the scheduled procedure, if known;
- 5. The billing provider ID number of the physician and/or physicians practice or other authorized provider that will render the requested service(s), if known;

Last Updated: 2/13/11

- 6. All clinical records to support the requested service (describing diagnostic studies and treatment completed to date along with results, and clinical records upon which the request has been made);
- 7. Additional information as determined by the Department or its Authorized Agent.
- B. Prior authorization may be effective for up to twelve (12) months as determined by medical criteria and documentation of ongoing necessity. In some cases, for covered health care expenditures that require PA, financial eligibility for medical services may be determined retroactively. MaineCare will provide reimbursement for these services if it can be shown that all Departmental requirements were met at the time the services were performed.
- C. For enrolled MaineCare members, the provider must verify the need for prior authorization with the Department and subsequently, ensure that authorization has been obtained when applicable. This must be done prior to provision of services, except in cases of medical emergency, or as described in Section 1.14-2 (B).

Effective 2/13/11

D. Notwithstanding any other provision herein, MaineCare Services or its Authorized Agent shall act on requests for prior authorization with reasonable promptness and shall adjust the time periods specified herein as circumstances require in order to do so. In circumstances that do not require an immediate decision, MaineCare Services or its Authorized Agent will make a decision to authorize or deny the request for PA within thirty (30) days of the receipt of the completed request, or thirty (30) days after the date the application is determined to be complete following a decision in an administrative hearing as provided herein, or services will be considered authorized. MaineCare Services will notify the provider and member of the decision.

Effective 2/13/11

E. The thirty (30) day provision regarding the treatment of complete requests shall not apply in the case of an emergency. In cases of an emergency, the prior authorization decision will be made expeditiously to address the emergency, including notifying the provider of an incomplete request.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont.)

Effective
2/13/11

- F. Providers who submit an incomplete request for authorization of services will be notified within thirty (30) days of receipt of the incomplete request. MaineCare Services or its Authorized Agent will defer the request until the specific additional information necessary to complete the request is received. Such notice shall be sent to the provider and member, within thirty (30) days of receipt of the incomplete request and shall clearly identify the following:
  - 1. the information necessary to complete the request;

# Effective 2/13/11

- 2. specific citation of the regulations requiring the information; and
- 3. the name and telephone number of the person in MaineCare Services or its Authorized Agent, who should be contacted should the provider and/or member have questions regarding the deferral.
- G. The member's provider shall make a reasonable effort to submit to MaineCare or its Authorized Agent the information requested within thirty (30) days from the date that notice is received that it is incomplete, failing which the application may be considered abandoned and may be denied for that reason. Any notice that an application is incomplete, sent out by MaineCare or its Authorized Agent, more than thirty (30) days from the date the original application was filed with MaineCare, shall be considered an adverse action by MaineCare. Such notice shall be accompanied with a statement advising the applicant of an opportunity for an administrative hearing to challenge the determination that the application is incomplete.

Effective 2/13/11

In the case of a notice of incompleteness given more than sixty (60) days from the date the original application was filed, the statement shall advise the applicant of an opportunity for an administrative hearing to determine not only whether the application is complete, but, in the event that it is deemed so, whether MaineCare Services should be ordered to take final action on the application within ten (10) days. Any such order by the administrative hearing officer shall provide that the request shall be considered authorized if a decision is not made within such ten (10) day period.

# Effective 2/13/11

- H. Once approval has been given, if the provider originally requesting prior authorization is unable or unwilling to provide the service requested within a reasonable time, the member may choose another provider. The second provider is responsible for notifying MaineCare Services of his/her intention to provide the service subject to the initial approval. MaineCare Services, upon request, will assist the member in attempting to locate a provider when the member is unable to do so.
- I. If the request for prior authorization is denied, MaineCare or its Authorized Agent will clearly explain the denial reasons in the denial notice. This explanation shall include any facts, circumstances, calculations, and other data that were used as a

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont.)

basis for making the denial and shall specify any additional information that could be supplied, by the provider or member, to permit the request to be approved. This explanation shall be set forth clearly and conspicuously and shall be phrased, to the extent possible, in simple terms easily understandable by a layperson.

J. MaineCare will not deny a request for services without examining the nature of the request to determine whether any portion of the services requested or reasonable alternative services thereto might be covered by MaineCare. A notice of denial shall be given when the services requested are denied in whole or in part. If a portion of the request is covered under MaineCare and a portion is not, MaineCare or its Authorized Agent shall give notice of a denial of only those services not covered and shall give approval of those services that are covered.

Effective 2/13/11

K. MaineCare Services or its Authorized Agent shall promptly refer requests for prior authorization for mental health services not covered (or for the portion of services not covered for partially denied services) by MaineCare to DHHS, Adult Mental Health Services or Children's Behavioral Health Services.

Such referrals will be made within three (3) business days of the determination that mental health services requested are not covered by MaineCare and shall be made to the appropriate regional office of DHHS by telephone or electronic mail or other method to ensure that the referral is received as soon as practicable. Any denial of requested services, in whole or in part, shall be accompanied by a statement advising the applicant of a right to an administrative hearing. If an applicant chooses to request a hearing, the request shall be made no later than thirty (30) days from the date of receipt of the notice and, if requested, MaineCare Services or its Authorized Agent, shall forward the request to the DHHS Office of Administrative hearings within twenty-four (24) regular business hours (that is, by the next day if not a holiday or weekend) and a hearing shall be held within seven (7) working days thereafter. (See Sections 1.21 & 1.22).

Effective 2/13/11

L. When a participating provider furnishes a service or equipment and has either failed to request PA or has been notified that PA has been refused, that provider is liable for the costs of those services and that provider may not bill either the Department or the member for such care or services, except in the following situation: Prior to the provision of the services the member shall acknowledge in writing that he or she is aware that PA has not been granted and, therefore, MaineCare will not pay for the services and that he or she accepts financial liability to pay for the services.

In addition, if and when a member chooses not to utilize the PA process, the service is considered non-covered by MaineCare if the member acknowledged in writing that he or she understood that he or she would assume financial responsibility for the service.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# 1.14 PRIOR AUTHORIZATION (cont.)

#### 1.14-2 Out-Of-State Services

Unless otherwise allowed in Chapter II of this Manual, medical care that is covered under MaineCare that is only available outside the State of Maine requires prior authorization. MaineCare will not guarantee payment for services received out-of-state unless prior authorization has been granted pursuant to the procedure outlined in Section 1.14-2(A).

Last Updated: 2/13/11

The provider is responsible for verifying the need for prior authorization and subsequently, that authorization has been obtained from the Department or its Authorized Agent when applicable. This needs to be done prior to provision of services, except in cases of medical emergency, or as described in Section 1.14-2 (B).

Prior authorization for services will be granted to out-of-state providers for covered services described in this Manual, only when a member's continuity of care must be preserved for medical reasons and only after it is determined that the needs of the member cannot be met in the State of Maine.

Effective 2/13/11

Notwithstanding any other provision herein, MaineCare Services or its Authorized Agent shall act on applications for prior authorization for out-of-state services with reasonable promptness and shall adjust the time periods specified herein as circumstances require in order to do so.

If the request for prior authorization is denied, MaineCare or its Authorized Agent will clearly explain the reasons for denial in the denial notice. This explanation shall include any facts, circumstances, calculations, and other data that were used as a basis for making the denial and shall specify any additional information that could be supplied, by the provider or member, to permit the request to be approved. This explanation shall be set forth clearly and conspicuously and shall be phrased, to the extent possible, in simple terms easily understandable by a layperson.

#### A. Procedure and Requirements for Out-Of-State Services

The procedure to request prior authorization is as follows:

- 1. Each member must be currently under the care of a licensed professional providing physician services, or a recognized primary care provider acting within the scope of his/her license, and practicing in the State of Maine, or within fifteen (15) miles of the Maine/New Hampshire border, or within five (5) miles of the Maine/Canadian border.
- 2. The request for prior authorization must be made by the Maine physician for services provided out-of-state. Criteria for prior authorization of out-of-state services shall be as set forth in this Chapter and in the specific section of this Manual covering those services. Prior authorization contact information and prior authorization forms can be found at:

Effective 2/13/11

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont.)

Effective 2/13/11

 $\frac{https://mainecare.maine.gov/Provider%20Forms/Forms/Publication1.aspx}{?RootFolder=\%2fProvider%20Forms%2fClaims&FolderCTID=&View=\\ \frac{\%7b55EF7D29\%2d59ED\%2d4CC1\%2dA015\%2d69037A886B14\%7dhtt}{p://www.maine/dhhs/oms/provider_index.html.}$ 

- 3. The request must be made at least thirty (30) calendar days prior to the date medical care/services are to be provided in another state. The only exception would be for medical or behavioral health emergency cases. In cases of such an emergency, the prior authorization decision will be made as soon as necessary to relieve the emergency. Emergency cases will be given special consideration and should be so identified by the physician or provider requesting approval. Telephone requests, which must be followed by written materials, will be accepted only in emergency situations. Faxed requests are allowed.
- 4. The provider's request for prior authorization must include:
  - a. Member's name;
  - b. Member's MaineCare identification number;
  - Diagnosis (describe diagnostic studies and treatment completed to date along with results, and clinical records upon which the request for out-of-state referral has been made). Send clinical records to support diagnosis and referral;
  - d. Names of physicians and/or facilities that the member has previously been referred in Maine for diagnosis and/or treatment. Include second opinion documentation;
  - e. Physicians consulted by attending physician relative to availability of diagnosis and/or recommended treatment in Maine. Send second opinion documentation supporting out-of-state referral;
  - f. Recommended treatment or further diagnostic work;
  - g. Reasons why medical care cannot be provided in Maine or the next closest location outside the State;
  - h. Names of physicians and facility outside of Maine to provide services and date of appointment(s) if known, and
  - i. Additional information if specified in applicable Chapters of this Manual.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont)

- 5. If additional information is needed or it appears that the service may be available within the State, the Department or its Authorized Agent reserves the right to require that the patient seek consultation and/or treatment from providers of the service within the State.
- 6. The reviewing Department or its Authorized Agent will notify the provider and member of approval or disapproval. If approved, a letter will be sent to the member and the out-of-state provider(s) authorizing medical care. The out-of-state provider must enroll as a MaineCare provider for the State of Maine and must accept MaineCare reimbursement as payment in full for the covered services authorized. The Department reserves the right to set rates for services. If disapproved, an explanation will be given, and notice of the member's right to request an administrative hearing will be given.
- 7. The procedures for granting, denying and processing requests for in state services, as set forth in Section 1.14-1, shall apply to requests for out-of-state services.
- 8. Once approval has been given, if the provider originally requesting prior authorization is unable or unwilling to provide the service requested within a reasonable time, the member may choose another provider. The second provider is responsible for notifying the applicable Department of his or her intention to provide the service subject to the initial approval and conditions set forth above. The applicable Department, upon request, will assist the member in attempting to locate a provider when he or she is unable to do so.
- 9. The attending physician in the State of Maine is expected to perform follow up for medical procedures provided out-of-state, unless medical necessity requires return to the out-of-state provider. Therefore, it is expected that the referring physician will receive medical reports of services provided by the out-of-state provider and follow the above procedures for any required out-of-state follow up.

# B. Exceptions

MaineCare will evaluate claims for MaineCare services rendered to eligible members out-of-state without prior authorization only under the following circumstances.

1. Emergency medical services rendered to members who are temporarily absent from the State, and for which they cannot reasonably be expected to return to Maine or because the member's health would be endangered if required to travel back to the State of Maine. Out of state emergency medical services will be reviewed for medical appropriateness. Providers must notify the Department, or its Authorized Agent, within one business day of an emergency admission for a MaineCare member. For inpatient emergency services, the

Effective 2/13/11

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont)

provider must seek and receive approval for an appropriate length of stay, determined by the Department or its Authorized Agent, based on the evidence of medical necessity provided in the member's medical documentation. In order to be reimbursed by MaineCare for emergency inpatient services, the provider must submit an authorization number on the claim form submitted to the Department. In cases where the provider is unable to confirm proof of MaineCare coverage (i.e. member is unconscious, or the member does not have MaineCare card readily available), the provider may exceed the one-day requirement by providing a sufficient explanation of the case.

- 2. MaineCare covered services rendered to eligible members who intend to remain out-of-state. The Office of Integrated Access and Support will determine when MaineCare coverage will terminate.
- 3. MaineCare covered services rendered to eligible members by qualified providers within fifteen (15) miles of the Maine/New Hampshire border and within five (5) miles of the Maine/Canadian border.
- 4. MaineCare covered services rendered to persons prior to their date of application, when eligibility is determined retroactively to cover the time period in which the services were provided.
- 5. MaineCare covered services received by qualified Medicare beneficiaries out-of-state when the providers have accepted Medicare assignment and only the deductible and coinsurance are to be billed.
- 6. MaineCare covered services provided through out-of-state, culturally appropriate, alcohol treatment and substance abuse services, that are fully reimbursed (100%) by Indian Health Service funds, and provided by enrolled MaineCare providers. These services are subject to post payment review by the Division of Program Integrity.
- C. Specific Requirements for Behavioral Health Emergencies and Mental Health Services for Children

Requests involving behavioral health emergencies are in a unique group that do not require prior authorization.

1. The definition of a behavioral health emergency is as follows:

The member displays significant, prolonged, escalation of volatile or suicidal behaviors to the point that the parent, guardian, or service provider is unable to reasonably assure the safety of the member and/or others. There must be clinical documentation of professional inability to secure safety, as well as inability to obtain the necessary behavioral health emergency services in the State of Maine.

SECTION 1

# GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.14 PRIOR AUTHORIZATION (cont)

# Effective 2/13/11

1.14-3 Early and Periodic Screening, Diagnosis and Treatment Services

MaineCare Services shall take reasonable and necessary steps to ensure that all requests for prior authorization of services for MaineCare members, under age twenty-one (21), are not denied without first taking reasonable steps to determine if the services can be authorized under the MaineCare Benefits Manual, Early and Periodic Screening, Diagnosis and Treatment Services. Reasonable steps may include, but are not limited to, contacting the provider to inform the provider of the Early and Periodic Screening, Diagnosis and Treatment Services for these treatment services. Such services include those medically necessary treatment/diagnostic services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the Early and Periodic Screening, Diagnosis and Treatment Services benefit and are described in a member's comprehensive plan of care.

These MaineCare covered services are furnished in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1989 and are covered under Federal regulations.

#### 1.14-4 Medical Necessity

# Effective 2/13/11

Some services under this section require prior authorization by the Department or its Authorized Agent. Prior authorization contact information and prior authorization forms, can be found at: <a href="http://www.maine.gov/dhhs/oms/provider\_index.html">http://www.maine.gov/dhhs/oms/provider\_index.html</a> The Department may use evidence-based criteria and/or may use criteria based on national standards for evaluating what is considered medically necessary.

# 1.15 PROVISION OF NECESSARY TRANSPORTATION TO MEDICAL SERVICES

Effective 2/13/11

MaineCare meets the Federal requirement to provide necessary (non-emergency) transportation (42 CFR 431.53) to MaineCare members who have no other means of transportation to MaineCare covered services. MaineCare reimbursement shall be made to transportation agencies having a Provider Agreement with the Department of Health and Human Services to provide transportation services for qualified MaineCare members as described in Chapter II, Section 113 of this Manual. The transportation agency must arrange transportation in the most economical manner that is suitable to the member's medical needs. Generally this will be to the nearest available provider, typically by fixed route service or volunteer driver, unless noted otherwise in the appropriate section of Chapter II of this Manual.

For necessary MaineCare covered services, providers or members may make requests for non-ambulance transportation to a transportation agency serving the area where the member resides. Requests for such transportation must be made in advance of an appointment as required in Chapter II, Section 113, Transportation Services, of the MaineCare Benefits Manual. MaineCare Member Services may be contacted when members need assistance in locating a transportation agency. The transportation agency must arrange transportation in the most economical manner that is suitable to the member's medical needs. Reimbursement for transportation services may be made retroactively to an enrolled transportation provider when applicable to a service for which the enrollee was retroactively determined to be eligible. Transportation agencies must reimburse drivers within two (2) weeks of receiving reimbursement from the Department.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### 1.16 AUDITS

The Division of Audit or duly Authorized Agents appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review.

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#### 1.17 UTILIZATION REVIEW

The Department or its Authorized Agent is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.

Delegation of any utilization review activities pertaining to length of stay in acute care hospitals will be carried out in accordance with the hospital's utilization review program/plan.

The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to the requests in a timely manner and at no charge to the Department.

#### 1.17-1 Behavioral Health Managed Care

The Department uses a behavioral health managed care system for all members receiving selected behavioral health services that are covered by MaineCare to ensure access to appropriate care and improve member outcomes.

The Department's Administrative Services Organization (Authorized Agent) is used for eligibility verification, utilization management, and for examination of clinical appropriateness for selected services as identified in the behavioral health services sections of the MaineCare Benefits Manual. The Authorized Agent performs the following duties: facilitates referrals to appropriate service providers; prior authorizes selected services; expedites delivery of services to members in need of treatment; tracks the service status of members enrolled in the system; and gathers data that will inform the Department of resource development needs. The Department's goal is to promote early intervention of services provided to avoid unnecessary reliance on emergency and inpatient services. All providers must submit notification of their intent to initiate behavioral health services identified in the MBM prior to the start of services for all members. The Department's Authorized Agent ASO must have prior notification of services for utilization review purposes to assess the medical necessity, efficiency, appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis.

Please refer to the appropriate Sections of the MaineCare Benefits Manual (MBM) for additional requirements and information on behavioral health managed care.

Effective 2/13/11

#### 1.18 PROGRAM INTEGRITY

The Program Integrity Unit, Division of Audit and/or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# Last Updated: 2/13/11

#### 1.17 UTILIZATION REVIEW(cont)

- A. a continuous sampling review of the utilization of care and services for which payment is claimed:
- B. an on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;
- C. an extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;
- D. a post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;

# Effective 2/13/11

- E. the implementation of the Restriction Plans (described in Chapter IV of this Manual);
- F. referral to appropriate licensing boards or registries as necessary; and
- G. referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases in which fraudulent activity is suspected.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to: treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and/or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

#### 1.19 SANCTIONS/RECOUPMENTS

# Effective 2/13/11

1.19-1 Grounds for Sanctioning and/or Recouping MaineCare payments from Providers, Individuals or Entities

The Department may impose sanctions and/or recoup identified overpayments against a provider, individual, or entity for any one or more of the following reasons:

- A. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise;
- B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
- C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements;

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### **1.19 SANCTIONS/RECOUPMENTS** (cont.)

- D. Failing to retain or disclose or make available to the Department or its Authorized Agent contemporaneous records of services provided to MaineCare members and related records of payments;
- E. Failing to provide and maintain quality services to MaineCare members within accepted professional or program standards as judged by peer reviewers;
- F. Engaging in a course of conduct or performing an act deemed improper, abuse of the MaineCare Program or continuing such conduct following notification that said conduct should cease.

Examples of such abusive acts include, but are not limited to, the following:

- 1. Furnishing services or supplies which are determined by the Department to be substantially in excess of the needs of, or harmful to, individuals, or to be of inferior quality, or not of usual or customary quality;
- 2. Soliciting or accepting from a member, his or her family, friend or other representative an amount over and above the reasonable charge amount or fee schedule for covered services (supplementation);
- 3. Maintaining a separate schedule of charges for MaineCare and non-MaineCare patients that results in higher charges for MaineCare than for non-MaineCare patients;
- 4. Billing based on "gang" visits, (for example, a dental provider in a school setting, or a physician visits a nursing home, walks through the facility, and bills for individual nursing home visits, without rendering any specific service to individual patients).

# Effective 2/13/11

- G. Breaching the terms of the MaineCare Provider Agreement, and/or the Requirements of Section 1.03-3 for provider participation;
- H. Over utilizing MaineCare by inducing, furnishing, or otherwise causing a member to receive service(s) or merchandise not otherwise required or requested by the member;
- I. Rebating or accepting a fee or portion of a fee or charge for a MaineCare member referral (kickback);

# Effective 2/13/11

J. Physician self-referrals determined to be in violation of Title XVIII, § 1877 of the Social Security Act (42 U.S.C. Section 1395nn), which prohibits certain physician self-referrals for designated health services, and 42 CFR 1001.951/952 and 42 CFR 411.353.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# Last Updated: 2/13/11

# **1.19 SANCTIONS/RECOUPMENTS** (cont.)

Designated health services include any of the following items or services:

- 1. clinical laboratory services;
- 2. physical therapy services;
- 3. occupational therapy services;
- 4. radiology services, including MRIs, CAT scans, and ultrasound services;
- 5. radiation therapy services and supplies;
- 6. durable medical equipment and supplies;
- 7. parenteral and enteral nutrients, equipment, and supplies;
- 8. prosthetics, orthotics, and prosthetic devices and supplies;
- 9. home health services;
- 10. outpatient prescription drugs;
- 11. inpatient and outpatient hospital services; and
- 12. speech-language pathology services
- K. Violating the applicable provision of any law governing benefits governed by this Manual, or any rule or regulation promulgated pursuant thereto;
- L. Submission of a false or fraudulent application for provider status;
- M Violation of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

# Effective 2/13/11

- N. Conviction of a criminal offense relating to performance of a Provider Agreement with the State, negligent practice resulting in death or injury to patients, or misuse or misapplication of program funds;
- O. Failure to meet standards required by State or Federal law for participation (e.g. licensure or certification requirements);
- P. Documented practice of charging members for services over and above the amount paid by the Department and/or charging members for services prior to receipt of MaineCare payments;

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.19 SANCTIONS/RECOUPMENTS** (cont.)

- Q. Failure to correct deficiencies in provider operations in accordance with an accepted plan of correction after receiving written notice of these deficiencies from the Department;
- R. Formal reprimand or censure by an association of the provider's peers for unethical practices;
- S. Suspension, exclusion or termination from participation in another governmental medical program, such as Medicare, Workers' Compensation, Children With Special Health Needs Program, and Rehabilitation Services, for fraudulent or abusive practices;
- T. Conviction for fraudulent billing practices, negligent practice, or patient abuse;
- U. Failure to repay or make arrangements to repay overpayments or payments made in error;
- V. Failure to return money paid by members to a provider for covered services rendered during any period of MaineCare eligibility, including failing to pay back members for services for which they were charged when they have eligibility determined retroactively and there is evidence of notification of retroactive eligibility for the member;
- W. Unauthorized use of a primary care provider's MaineCare Identification number as described in Section 1.03-7;
- X. Breach of the terms of legal and binding contract(s) with contractor(s) or subcontractor(s) who provide their contractual services to MaineCare members; or
- Y. Failure to abide by the provisions of 42 CFR 1000 *et seq.*, pertaining to the exclusion of individuals and entities.

#### 1.19-2 Sanction Actions

The following sanctions may be invoked against providers, individuals or entities based on the grounds specified in Section 1.19-1, in accordance with applicable State and Federal rules and regulations.

- A. Termination/Exclusion from participation in MaineCare;
- B. Suspension of participation in MaineCare;
- C. Withholding or offset of future payments toward recoupment of prior MaineCare reimbursements:
- D. Transfer to a closed-end Provider Agreement not to exceed twelve (12) months or the shortening of an already existing closed-end Provider Agreement;

Effective 2/13/11

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# 1.19 SANCTIONS/RECOUPMENTS (cont.)

E. If the provider is a nursing facility or an ICF-MR (as defined in Chapter II, Section 67 or 50 of this Manual), and if the grounds for this sanction are based on the provider's failure to comply with 42 U.S.C. 1396r, Subsections (b) Requirements Relating to Provision of Services, (c) Requirements Relating to Residents' Rights, and/or (d) Requirements Relating to Administration and Other Matters (refer to Section 1.19-1(N) of this Manual), then the Department may sanction the provider by denying payment for all MaineCare admissions which take place after the date on which the Department gives notice to both the provider, and to the public, that the provider is out of compliance with 42 U.S.C. 1396 (b), (c) and/or (d).

Notwithstanding the delineation of provider appeal rights in Section 1.21-1 (A) of this Manual, this sanction may be enforced immediately if the noncompliance jeopardizes the health and safety of residents or three months after the facility is notified of the noncompliance if the facility has not been brought into compliance within that three-month period. Hence, under these particular circumstances, this sanction may be enforced prior to and during the appeal process.

- F. Forfeiture of any payment for services, supplies or goods, associated with grounds for sanctioned providers.
- G. Imposition of penalty due to lack of adequate documentation. When the Department proves by a preponderance of the evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services, the Department in its discretion may impose the following penalties:
  - 1. A penalty equal to one hundred percent (100%) recoupment of MaineCare payments for services or goods, if the provider has failed to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members.
  - 2. A penalty not to exceed twenty-percent (20%), if the provider is able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. The penalty will be applied against each MaineCare payment associated with the missing mandated records.

#### 1.19-3 Rules Governing the Imposition and Extent of Sanction

A. Imposition of Sanction

Effective 2/13/11

The decision to impose a sanction shall be the responsibility of the Commissioner of the Department of Health and Human Services, who may delegate sanction responsibilities to the Division of Audit, and the Director of MaineCare Services.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.19 SANCTIONS/RECOUPMENTS** (cont.)

- 1. The following factors may be considered in determining the sanction(s) to be imposed:
  - a. Seriousness of the offense(s);
  - b. Extent of violation(s);
  - c. History of prior violation(s);
  - d. Prior imposition of sanction(s);
  - e. Prior provision of provider education;
  - f. Provider willingness to obey MaineCare rules;
  - g. Whether a lesser sanction will be sufficient to remedy the problem; and
  - h. Actions taken or recommended by peer review groups, other payors, or licensing boards.
- 2. Where a provider, individual or entity, has been convicted of defrauding the MaineCare Program, or has been previously suspended due to MaineCare Program abuse, or has been terminated from the Medicare Program for abuse, the Department shall institute proceedings to terminate participation of the provider, individual or entity, from the MaineCare Program.
- 3. Nursing facilities that fail to comply with State licensing regulations may be subject to the imposition of sanctions and/or Federal penalties as described in Chapter 22, (Enforcement), of the Department's policy titled: Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.

#### B. Scope of Sanction

- 1. A sanction may be applied to a provider, individual, or entity, or to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances.
- 2. Suspension or termination from participation of any provider, individual or entity shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Department or its Authorized Agents for any services or supplies provided under MaineCare except for those services or supplies provided prior to the suspension or termination.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# **1.19 SANCTIONS/RECOUPMENTS** (cont.)

3. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Department or its Authorized Agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in MaineCare except for those services or supplies provided prior to the suspension or termination.

Last Updated: 2/13/11

4. When a provider of services that is a clinic, group, corporation or other association are in violation of the provisions of Section 1.19-3(B)(3), the Department may suspend or terminate such organization and/or any individual within said organization that is responsible for such violation, and administer other sanctions.

#### C. Notice of Sanction

- 1. When a provider, individual or entity, has been sanctioned and/or a recoupment has been imposed, the Department shall notify, if appropriate, the applicable professional society, Board of Registration or Licensure, his or her employer, and Federal or State agencies of the findings made and the sanctions imposed.
- 2. Once a provider, individual or entity's participation in MaineCare has been suspended or terminated, the provider must notify all affected MaineCare members within thirty (30) days that the provider, individual or entity, has been suspended or terminated and must arrange orderly transfer of records to other providers as applicable.

#### 1.19-4 Notice of Violation/Recoupment

If the Department has information that indicates that a provider may have submitted bills and/or has been practicing in a manner inconsistent with the program requirements, and/or may have received payment for which he or she may not be properly entitled, the Department shall notify the provider of the discrepancies noted. The written notification shall be sent to the provider allowing at least sixty (60) calendar days from the date of the notice before the effective date of any further action or imposition of sanction pursuant to state and federal laws, unless the life and/or safety of the member is felt to be endangered which would be cause for immediate sanction, and shall set forth:

- A. The nature of the discrepancies or violations;
- B. The dollar value of such discrepancies or violations;
- C. The method of computing such dollar value may be from:
  - 1. extrapolation from a systematic random sampling of records,
  - 2. a calculation from a selective sample of records, or

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.19 SANCTIONS/RECOUPMENTS** (cont.)

- 3. a total review of all records.
- D. Any further actions to be taken or sanctions to be imposed by the Department; and
- E. Any actions required of the provider, and the right to request an informal review and administrative hearing, as set forth in Section 1.21. An adverse decision may be appealed pursuant to the procedures outlined in Section 1.21 of this Chapter. A request for review or proceedings there under, does not stay the sanction imposed by the Department.

#### 1.19-5 Reinstatement Procedures from Termination or Exclusion

# Effective 2/13/11

A request for reinstatement must be addressed to the Manager of Program Integrity.

Any sanctions, including outstanding monetary sanctions, will be a factor in determining whether an individual or entity will be considered for reinstatement as a participant in the MaineCare Program. Any request for reinstatement will be reviewed in relation to any decisions or actions made by the United States Department of Health and Human Services, to past actions in MaineCare and to other relevant factors such as professional sanctions.

1.19-6 Suspension or Withholding of Payments Pending a Final Determination

The Department may impose a sanction or withhold payment when the Department has obtained an order from Superior Court allowing interim sanctions upon showing a substantial likelihood that overpayment or fraud has occurred and that substantial harm to the Department will result from further delay or when the Department has taken final agency action and the provider has waived or exhausted its right to judicial review.

The Department may terminate or suspend the participation of a provider in MaineCare pursuant to Federal and State rules and regulations.

1.19-7 Procedures Following a Suspension

Except as otherwise directed by the Department, the Provider under suspension shall:

- 1. Not accept new members for services unless otherwise specifically requested in writing on an individual case basis by the Department.
- 2. Furnish the Department with access to all information pertaining to each individual member presently being cared for by the Provider in such detail as deemed necessary by the Department.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY

#### 1.20-1 Fraud

- A. Fraud includes intentional deception or misrepresentation, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits.
   The requisite intent is present if the misrepresentation was made knowingly or with a reckless disregard for the truth.
- B. Examples of conduct that could constitute fraud include, but are not limited to, the following:
  - 1. Billings for services, supplies, or equipment that were not rendered to, or used for, MaineCare members;
  - 2. Billings for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;
  - 3. Flagrant and persistent over utilization of medical or paramedical services with little or no regard for results, the member's ailments, condition, medical needs, or the provider's orders;
  - 4. Claiming of costs for non-covered or non-chargeable services, supplies or equipment disguised as covered items;
  - 5. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the member or the individual who rendered the services;
  - 6. Duplicate billing which appears to be deliberate. This includes, but is not limited to: billing MaineCare twice for the same service or billing both MaineCare, a third party insurer, and/or the member/family/representative for the same services, billing for the same service under different codes or different policies, billing separately for a service that is included in a per diem or other bundled rate, or billing for the same service under different provider numbers;
  - 7. Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge MaineCare with various devices (commissions, fee splitting) used to siphon off or conceal profits;
  - 8. Charging to MaineCare, by subterfuge, costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses of principals;

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY (cont)

9. Deliberately providing, or receiving medical services on the MaineCare account of another individual;

# Effective 2/13/11

- 10. Deliberately billing members rather than MaineCare for covered services;
- 11. Concealing business activities that would prevent compliance with the provisions of the Provider Agreement;
- 12. Falsifying provider records in order to meet or continue to meet the conditions of participation; and
- 13. Soliciting, offering, or receiving a kickback, bribe, or rebate.

#### 1.20-2 Statutory Provisions

- A. The State of Maine participates financially in MaineCare. Therefore, provider claims for payment from MaineCare are subject to Maine Statutes pertaining to criminal fraud including the following:
  - 1. 17-A M.R.S.A. §354, Theft by Deception, makes it a crime to obtain or exercise control over property of another as a result of deception, and with an intention to deprive a person thereof.
  - 2. 17-A M.R.S.A. §453, Unsworn Falsification, makes it a crime if a person makes a written false statement which he or she does not believe to be true, on or pursuant to, a form conspicuously bearing notification authorized by Statute or Regulation to the effect that false statements made therein are punishable; or with the intent to deceive a public servant in the performance of his or her official duties, he or she makes any written false statement which he or she does not believe to be true; or knowingly creates, or attempts to create a false impression in a written application for any pecuniary or other benefit by omitting information necessary to prevent statements therein from being misleading and is punishable as a Class D crime.
  - 3. Title 17-A M.R.S.A. §151, the Conspiracy Statute, makes it a crime if, with the intent that conduct be performed which, if fact, would constitute a crime or crimes, a person agrees with one or more others to engage in or cause the performance of such conduct.
- B. The Federal Government also participates financially in MaineCare. Therefore, provider claims for payment from MaineCare are subject to Federal statutes pertaining to Criminal Fraud including the following:
  - 1. 18 U.S.C. §286, which makes it a crime to enter into an agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain payment of a false claim;

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79

# 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY (cont)

2. 18 U.S.C. §287, which makes it a crime to present a claim against the United States knowing it to be false;

Last Updated: 2/13/11

- 3. 18 U.S.C. §371, which makes it a crime for two or more persons to conspire to commit an offense against the United States or to defraud in any manner or for any purpose;
- 4. 18 U.S.C. §669, which makes it a crime to embezzle, steal, or intentionally misapply money, funds, property, or other assets of a health care benefit program.
- 5. 18 U.S.C. §1001, which makes it a crime for any person in any manner within the jurisdiction of any Department of the United States to knowingly conceal a material fact, or make false statement or representations, or make or use any false writing or document knowing it to be false; and
- 6. 18 U.S.C. §1035, which makes it a crime for any person involved in any manner with a health care benefit program to knowingly and willfully makes false, fictitious, or fraudulent oral or written statement or representation of a material fact.
- 7 18 U.S.C. §1341, which makes it a crime for any person to use the postal service for purposes of executing or intending to execute any fraudulent scheme or artifice.
- 8. 18 U.S.C. §1347, which makes it a crime for any person to knowingly and willfully defraud, or obtain by false pretense, through the delivery of or payment for health care benefits any money or property owned by any health care benefit program.
- 9. 18 U/S.C. §1516, which makes it a crime for any person to influence, obstruct, or impede a Federal auditor in the performance of official duties.
- 10. 18 U.S.C. §1518, which makes it a crime for any person to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator.
- 11. 31 U.S.C. §3729(c) False Claims Act See Chapter I, Appendix #3, of this Manual.

Because MaineCare is subject to Federal statutes in order to receive Federal funding, compliance with Federal regulations and/or law is necessary, and requires that such laws will supersede any State regulation that may be contradictory.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY (cont)

C. Section 42 U.S.C. §1320a-7 (b) of the Social Security Act provides that

#### 1. Whoever

- a. knowingly and willfully makes or causes to be made any false statement or representation of a material fact in application for any benefit or payment under the State Plan approved under this Title;
- b. at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment;
- c. having knowledge of the occurrence of any event affecting:
  - (i) his or her initial or continued right to any such benefit or payment; or
  - (ii) the initial or continued right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulent to secure such benefits or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
- d. having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;
- presents or causes to be presented a claim for a physician's service e. for which payment may be made under a program under the State Plan approved under this Title and knows that the individual who furnished the service is not licensed as required, shall in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, shall be guilty of a felony and upon conviction thereof, fined no more than twenty-five thousand dollars (\$25,000) or imprisoned for not more than five (5) years or both or in the case of such a statement, representation, concealment, failure, or conversion by another person, be guilty of a misdemeanor and upon conviction thereof fined not more than ten thousand dollars (\$10,000) or imprisoned for not more than one year, or both.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

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# 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY (cont)

In addition, in any case where an individual who is otherwise eligible for assistance under a State Plan approved under this Title is convicted of an offense under the preceding provisions of this Sub-Section, the State may at its option (not withstanding any other provision of this Title or of such Plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

- 2. Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind;
  - a. In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Title, or
  - b. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, be fined not more than twenty-five thousand dollars \$25,000 or imprisonment for not more than five (5) years, or both.
- 3. Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly overtly or covertly, in cash or kind to any person to induce such person:
  - a. To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
  - b. To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility service, or item for which payment may be made in whole or in part under this Title, shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars (\$25,000) or imprisoned for not more than five (5) years, or both.

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

#### 1.20 FRAUD/ABUSE BY A PROVIDER, INDIVIDUAL OR ENTITY (cont)

Effective 2/13/11

- 4. Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification) as a hospital, nursing facility, intermediate care facility for the mentally retarded, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty- five thousand dollars (\$25,000) or imprisoned for not more than five (5) years, or both.
- 5. Whoever knowingly and willfully:
  - a. Charges a member, for any service provided to that member under a State Plan approved under this Title, money or other consideration at a rate in excess of the rates established by the State, or
  - b Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State Plan approved under this Title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):
    - i. As a precondition of admitting a patient to a hospital,
    - ii. As a requirement for the patient's continued stay in such a facility when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State Plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than twenty-five thousand dollars (\$25,000) or imprisoned for not more than five (5) years or both.

# 1.21 PROVIDER APPEALS

#### 1.21-1 General Principles

Effective 2/13/11

Any provider who is aggrieved by a Departmental action made pursuant to this Manual (excluding emergency terminations as referenced in Section 1.19-3-D) has sixty (60) calendar days from the date of receipt of that decision, to request an informal review. The request for an informal review must be in writing, to the Director of MaineCare Services or other specified Departmental official. This review will be conducted by the Director of MaineCare Services, or other designated Department representative who was not involved in the decision under review. The informal review will consist solely of a review of documents in the Department's possession including submitted materials/documentation and, if deemed necessary by the Department, it may include a personal meeting with the provider to obtain clarification of the materials. Issues that are not raised by the provider, individual, or entity through the written request for an informal review or the submission of

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.21 PROVIDER APPEALS** (cont.)

additional materials for consideration prior to the informal review are waived in subsequent appeal proceedings. The request for informal review may not be amended to add further issues.

Effective 2/13/11

Requests for informal reviews shall be submitted to MaineCare Services or other designated Department representative unless otherwise directed by the governing sections of Chapter II or Chapter III of this Manual. A written report of the decision resulting from that review will be issued to the provider.

#### A. Administrative Hearing

A provider must properly request an informal review and obtain a decision before requesting an administrative hearing. If the provider is dissatisfied with the informal review decision, he or she may write the Commissioner of the Department of Health and Human Services to request a hearing provided he/she does so within sixty (60) calendar days of the date of receipt of the informal review report on the Department's action. Subsequent appeal proceedings will be limited only to those issues raised during the informal review process.

The Office of Administrative Hearings shall notify the provider in writing of the date, time and place of the hearing, and shall designate a presiding officer. Providers will be given advance notice of at least twenty (20) calendar days from the mailing date of the hearing date. The hearing shall be held in conformity with the Maine Administrative Procedures Act, 5 M.R.S.A. §8001 *et seq.* and the Administrative Hearings Regulations.

The presiding officer shall issue a written decision and findings of fact to the provider or, pursuant to provisions of the Administrative Hearings Regulations, issue a written recommendation to the Commissioner of Health and Human Services. The Commissioner will then make the final decision. Legal counsel may represent providers at a hearing, and may request or subpoena persons to appear at the hearing where they can be expected to present testimony or documents relating to issues at the hearing. If the provider is dissatisfied with the final decision, an appeal may be taken to the Superior Court pursuant to the Administrative Procedure Act.

#### B. Arbitration Alternative

In lieu of the administrative hearing procedure, the parties may choose binding arbitration by a qualified arbitrator or panel of arbitrators as an alternative means of resolving a dispute. Both parties must agree to this optional method of dispute resolution. The Maine Uniform Arbitration Act shall regulate the arbitration. A provider's request for arbitration must be made within sixty (60) days from the date of receipt of the informal review decision prompting the request. Issues for arbitration shall be limited to those issues raised during the informal review. The arbitrator or panel of arbitrators must be selected and compensated as agreed by both parties.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.21 PROVIDER APPEALS** (cont.)

If the parties cannot agree to the terms of arbitration, the arbitration alternative will not apply and the normal procedures of administrative hearing with the option of appeal to the Superior Court will apply. If agreement for arbitration cannot be reached, a timely request for arbitration shall be construed as a request for an administrative hearing and all other terms of an administrative hearing shall apply. Arbitration is only available as an option when the amount in controversy is ten thousand dollars (\$10,000) or less and the subject matter in controversy is assessments, recovery or recoupment orders, sanctions, or administrative fines. A provider choosing arbitration may waive any right of appeal.

# 1.21-2 Appeal Options by Type of Facility

A. Special additional procedures apply to appeals for nursing facilities, residential care facilities, adult family care homes, and Intermediate Care Facilities for People with Mental Retardation (ICF-MR) for which the certification or provider enrollment/agreement is denied, terminated or not renewed for MaineCare.

Effective 2/13/11

Any nursing facility, residential care facility, adult family care home, or ICF-MR for which the MaineCare certification or Provider Agreement is denied, terminated or not renewed must be given an opportunity for a full evidentiary hearing on the denial, termination or nonrenewal. A facility representative must request a hearing within thirty (30) calendar days of the notice of the Department's informal review decision.

- 1. If the facility requests an administrative hearing, it must be completed either before the effective date of the denial, termination or nonrenewal or within one hundred and twenty (120) calendar days after that date.
- 2. The hearing must, at a minimum, include:
  - a. Timely written notice to the facility of the basis for the decision and disclosure of the evidence on which the decision is taken;
  - b. An opportunity for the facility to appear before an impartial decision maker to refute the basis for the decision;
  - c. An opportunity for the facility to be represented by counsel or another representative;
  - d. An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence;
  - e. An opportunity for the facility to cross-examine witnesses; and
  - f. A written decision by the impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.21 PROVIDER APPEALS (cont.)

B. Medicare/MaineCare Participating Nursing Facilities: Federal Appeal Option

In accordance with 42 CFR §431.153, if a nursing facility is participating, or seeking to participate, in both Medicare and MaineCare, and if the basis for the State's denial, termination or nonrenewal of participation in MaineCare is also a basis for denial, termination or nonrenewal of participation in Medicare, the State must advise the facility that:

- 1. The facility is entitled to the review procedures specified for Medicare facilities in Part 405, Subpart R, Title 42 of the Code of Federal Regulations in lieu of the procedures specified above; and
- 2. A final decision entered under the Medicare review procedures will be binding for purposes of MaineCare participation.
- C. Certified Nursing Facility Informal Reconsideration

If the State decides to provide the opportunity for an administrative hearing as outlined in this section only after the effective date of a denial, termination or nonrenewal, the State must offer the facility an informal reconsideration, to be completed before the effective date. The informal reconsideration must, at a minimum, include:

- 1. Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;
- 2. A reasonable opportunity for the facility to refute those findings in writing;
- 3. A written affirmation or reversal of the denial, termination, or nonrenewal;
- 4. If the provider is still dissatisfied with the decision, he or she may write the Commissioner of the Department of Health and Human Services to request an administrative hearing provided he or she does so within thirty (30) calendar days of the date of the Director's informal reconsideration decision.

#### 1.22 MEMBER APPEALS

1.22-1 Right to Administrative Hearing

In accordance with 42 CFR §431.220 the Department must grant an opportunity for a hearing to:

A. Any member who requests it because his or her claim for services is denied or not acted upon with reasonable promptness; and

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79 Last Updated: 2/13/11

### 1.22 MEMBER APPEALS (cont)

- B. Any member who requests it because he or she believes the agency has erroneously terminated, reduced, or suspended MaineCare medical eligibility or covered services.
- 1.22-2 Notice of Intent to Deny, Terminate, Reduce or Suspend MaineCare Eligibility or Covered Services
  - A. Notice must be mailed or delivered in person to the member when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services or when there has been a determination by a skilled nursing facility or nursing facility to transfer or discharge residents, as set forth below.

Specific information that must be in this notice includes:

- 1. A statement of the intended action.
- 2. An explanation of the reasons for the action, as well as a specific citation to the underlying State or Federal regulations that support the action.
- 3. A statement that the member has a right to a hearing.
- 4. An explanation of exactly how to obtain a hearing.
- 5. A statement that a member may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the member in arranging for legal counsel.
- 6. The name and telephone number of the person who should be contacted, should the member have questions regarding the notice.
- 7. An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.
- B. Advance notice must be mailed or delivered in person to a member at least ten (10) calendar days before an action to deny, terminate, suspend, or reduce services becomes effective, except as required by licensing of other State mandates. A member is presumed to have been provided a notice if there is evidence of when the notice was placed in the mail system or delivered in person.

The advance notice requirement applies unless:

- 1. the Department has facts indicating that the action should be taken because of probable fraud, and the facts have been verified if possible, in which case advance notice of five (5) calendar days is required.
- 2. the Department has factual information confirming the death of a member;

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# **1.22 MEMBER APPEALS** (cont)

- 3. the agency receives a clear written statement, signed by the member, that the member no longer wishes services; or gives information that requires termination or reduction of services and indicates that the member understands that this termination or reduction is the result of giving that information.
- 4. the member has been admitted to an institution where he or she is ineligible for further services;
- 5. the member's whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address;
- 6. the member has been accepted for services by another local jurisdiction, State or territory; or
- 7. a change in the level of medical care is prescribed by the member's physician or primary care provider where authorized.
- C. Continuation of MaineCare eligibility or services during the appeal process applies as follows:
  - 1. In accordance with 42 CFR § 431.230 and when this section requires advance notice, MaineCare Services currently being provided will not be terminated, reduced, or suspended until an administrative hearing decision is rendered provided that the member requests an administrative hearing before the date of action. This applies unless it is determined at the hearing that the sole issue is one of Federal or State law or policy, and the Department promptly informs the member in writing that services are to be terminated, reduced or suspended while awaiting the hearing decision.
  - 2. The date of action means the intended date on which a termination, reduction or suspension becomes effective.
  - 3. For Order of Reference decisions, as defined in the Administrative Hearings Regulations, the Department will take action to terminate, reduce or suspend services five (5) business days from the date of the final decision signed by the Commissioner.

#### 1.22-3 Procedure to Request an Administrative Hearing

A member may request an administrative hearing if he or she is aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Members must follow the procedures described in this section when requesting an administrative hearing.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

# 1.22 MEMBER APPEALS (cont)

- A. A member or his/her authorized representative may request an administrative hearing.
- B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal.

Last Updated: 2/13/11

- C. Unless otherwise specified in this Manual, the request must be made by the member or his or her representative, in writing or verbally, to: MaineCare Member Services, P. O. Box 709, Augusta, ME 04332, or an address otherwise specified by the Department in a written notice, for a hearing with the Office of Administrative Hearings, Department of Health and Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to the Director of MaineCare Services, and to the Office of Administrative Hearings, within one (1) business day of receiving the request.
- D. The hearing will be held in conformity with the Maine Administrative Procedures Act, 5 M.R.S.A. §8001 *et. seq.* and the Department's Administrative Hearings Regulations.
- E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the Office of Administrative Hearings, and a preliminary notice will be given at least ten (10) calendar days, from the mailing date. Shorter notice may be given in order to comply with provisions of Section 1.14-1 governing denials of mental health services. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing at a location near the member or by telephone or interactive television system.
- F. The Department and the member may be represented by others, including legal counsel and may have witnesses appear on his or her behalf.
- G. An impartial official will conduct the hearing.
- H. The hearing officer on his or her own motion or at the request of either Department representatives or the member may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.

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# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.22 MEMBER APPEALS (cont)

- I. When a medical assessment as defined in 42 CFR § 431.240 (3) (b) by a medical authority other than the one involved in the decision under question is requested by the hearing officer or the member, and considered necessary by the hearing officer, it will be obtained at the Department's expense, and forwarded to the member or the member's representative and hearing officer allowing both parties to comment.
- J. When the member, the Department, or an Authorized Agent of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.
- K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Health and Human Services will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision-making authorization to him or herself.
- L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

### 1.22-4 Dismissal of Administrative Hearing Requests

- A. If any of the following circumstances exist, the Office of Administrative Hearings may dismiss the request for an administrative hearing. This dismissal is the final agency action on the matter.
  - 1. The member withdraws the request for a hearing.
  - 2. The member, without good cause, abandons the hearing by failing to appear.
  - 3. The sole issue being appealed is one of Federal or State law requiring an automatic change adversely affecting some or all members. The procedure to follow when requesting a change in State policy is described in Section 1.06-4(D) of this Manual.
- B. Where an applicant's or member's request for an administrative hearing is dismissed pursuant to this section, the Office of Administrative Hearings shall notify the member of his/her right to appeal that decision in Superior Court.

#### 1.22-5 Corrective Action

The Department must promptly make corrective payments when appropriate, retroactive to the date an incorrect action was taken by the Department if:

- A. The hearing decision is favorable to the applicant or member; or
- B. The agency decides in the applicant or member's favor before the hearing.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.23 MAINECARE ADVISORY COMMITTEE

#### 1.23-1 Definitions

The MaineCare Advisory Committee is a committee required by Federal statute (Section 1902(a) (22) of the Social Security Act) and by the State Plan (Section 1.4), to advise the MaineCare agency about health and medical care services. Policy for the Committee is set forth in Section 431.12, Title 42, (Chapter IV) of the Code of Federal Regulations.

# 1.23-2 Purposes

The MaineCare Advisory Committee shall advise MaineCare Services and the Office of Integrated Access and Support of the Department of Health and Human Services on MaineCare issues including but not limited to:

- A. the development of policies and standards;
- B. suggested solutions to problem areas within the program;
- C. legislative initiatives relevant to the program;
- D. relationships and communications with providers;
- E. fee schedules for providers;
- F. utilization of services by members;
- G. content and dissemination of program materials;
- H. member issues, particularly concerning access to services; and
- I. eligibility standards and other issues related to eligibility.

The MaineCare Advisory Committee shall be given adequate opportunity for meaningful participation in the consideration of these issues. The Committee's advice shall be sought at such a time and in such a manner that best ensures it will be effectively considered by the Department. The duty to consult with the MaineCare Advisory Committee as established by this section shall apply not only to matters initiated by the Department, but also when possible, and as appropriate, those initiated by the Administration and the State Legislature to the extent that the Director has knowledge of them.

The advice of the Committee is not binding upon the Department.

#### 1.23-3 Members of the Committee

- A. Responsibilities and Privileges:
  - 1. attends committee meetings;
  - 2. work on subcommittees;

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

#### 1.23 MAINECARE ADVISORY COMMITTEE (cont)

- 3. participate in programs, workshops, or hearings called by the Committee; and
- 4. promote the Committee and its goals.

### B. Appointments

Effective 2/13/11

The Director of MaineCare Services, taking into consideration the nominations of the current membership and other interested parties, shall appoint members of the Committee. There shall be no less than fifteen (15) and no more than twenty-three (23) members on the Committee. At least fifty-one (51) percent of the membership must consist of members and member representatives. A member is an individual that currently or in the past has received Medical Assistance benefits under MaineCare.

- 1. Member representatives shall be appointed, taking into account nominations from currently active and appropriate organizations representing: persons of low income, older citizens, persons with physical or psychological disabilities, community organizations, children, minority groups, and other member groups.
- 2. Provider representatives shall be appointed taking into account the nominations of currently active and appropriate organizations representing those who provide a variety of services to a wide range of members in various settings.
- 3. Each member shall be appointed to a three (3) year term commencing at the first meeting after Labor Day, and may be re-appointed for additional three (3) year terms after serving a full term. Appointments shall be made on a staggered basis, so that one third of the Committee is subject to reappointment each year.
- 4. Appointed members of the Committee who find themselves unable for an extended period of time to exercise their Committee responsibilities, shall resign from the Committee in order to make room for a more active member.
- 5. Organizations represented by an individual who is absent from three (3) consecutive meetings without communicating a good and just cause to members of the Committee, will be notified of the absences in writing, by the chairperson. Copies of the notification letter shall be sent to the Director of MaineCare Services, and the absent member, who will have fourteen (14) calendar days to respond.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

# 1.23 MAINECARE ADVISORY COMMITTEE (cont)

6. The Director of the Office of Integrated Access and Support, or his or her representative or Authorized Agent, shall attend meetings and respond to issues related to eligibility standards and determinations.

#### 1.23-4 Officers and Subcommittees

#### A. Officers

The Committee shall have the following officers:

# 1. Chairperson

The chairperson shall be a member or member representative.

# 2. Vice Chairperson

Officers shall have the same power to make motions and to vote as other members of the Committee.

#### B. Election of Officers

The members of the Committee shall elect the chairperson and vice chairperson at the first meeting of the Committee following Labor Day.

#### C. Duties of Officers

#### 1. Chairperson

The chairperson shall:

- a. preside at meetings of the Committee;
- b. plan the agenda for Committee meetings in consultation with the staff:
- c. have the power to call special meetings of the Committee;
- d. serve, ex-officio, and without vote, on all subcommittees;
- e. work regularly with the staff and other members of the Committee in planning and implementing Committee action;
- f. act as official representative interpreting and disseminating decisions of the Committee; and
- g. appoint the chairperson of each subcommittee.

SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

#### MAINECARE ADVISORY COMMITTEE (cont)

### 2. Vice Chairperson

The vice chairperson shall:

- a. assist in all above-mentioned duties of the chairperson; and
- b. conduct Committee meetings in the absence of the chairperson.

Last Updated: 2/13/11

#### D. Subcommittees of the Committee

The Committee shall establish subcommittees as necessary, the members to be appointed by the chairperson. No less than three (3) members shall constitute a subcommittee. Non-members of the Committee may serve on Committee subcommittees with the approval of the Committee chairperson of the specified subcommittee. They shall not be voting members of the subcommittee.

#### 1.23-5 Meetings of the Committee

The Committee shall meet no less than six (6) times during a year. Regular meetings shall be held at a date, time, and place determined by the Committee.

# Effective 2/13/11

1.23

Special meetings may be called by the chairperson, or at the request of MaineCare Services or upon the written request of at least two (2) Committee members to the chairperson, stating the reason for the special meeting. Special meetings would be convened in the event of an emergency that in the judgment of the chairperson cannot wait until the next regular meeting. The Director of MaineCare Services shall notify the Committee members of the date, time, place, and agenda in advance of any scheduled or special meetings.

#### 1.23-6 Attendance at Committee Meetings

Members of the Committee are expected to attend all meetings of the Committee. A member may delegate a substitute representative, in his or her absence, with prior notification to the Committee staff person. The Committee staff person is expected to attend all meetings of the Committee.

## 1.23-7 Staff Support

A staff person shall be assigned to the Committee. The staff shall:

- A. provide staff support for all Committee meetings, including minutes of committee meetings, dissemination of materials, and coordination of programmatic initiatives;
- B. record and distribute minutes of meetings;
- C. provide independent technical assistance to the Committee, as necessary; and

# Effective 2/13/11

D. be responsible for carrying out the policies and directives of the chairperson and the Committee, within the policies and available resources of the Department and MaineCare Services.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established: 7/1/79

Last Updated: 2/13/11

#### 1.23 MAINECARE ADVISORY COMMITTEE (cont)

#### 1.23-8 Powers

#### A. Decision-making

The Committee acts through duly recorded votes of members of the Committee during meetings of the Committee as a whole. Binding Committee action can be taken only when a quorum of the Committee is present. A quorum is defined as at least five Committee members including the chairperson or vice chairperson.

# B. Public Statements by Committee Members

Committee members may make personal statements on public matters and may report on actions taken by the Committee but may not make an official statement on behalf of the Committee unless expressly authorized to do so by the chairperson of the Committee who may not give such approval unless the issue has been discussed at a meeting of the MaineCare Advisory Committee and supported by a majority of the Committee members present at that meeting.

# C. Annual Program and Budget Review

The Committee shall make an annual assessment of State agency's policies, benefit and budget proposals related to MaineCare, and may make recommendations thereon.

#### D. Appearance before the Legislature

Committee members may make personal statements on public matters and may report on actions taken by the Committee but may not appear before the Legislature on behalf of the Committee unless expressly authorized to do so by the chairperson of the Committee who may not give such approval unless the issue has been discussed at a meeting of the MaineCare Advisory Committee and supported by a majority of the Committee members present at that meeting. Any testimony must clarify the Committee's role as advisory to the Department.

### E. Regular Review of Policy Developments

At each regularly scheduled meeting, the Committee shall be provided with a list of all policy issues related to MaineCare that are currently under consideration by the Office of Integrated Access and Support or MaineCare Services. Those issues shall include all those on which the Department has a duty to consult with the Committee in accordance with Section 1.23. In addition, it shall list the subject matter of all currently proposed rules and issues scheduled for rulemaking within the next month, and the stage of those proposals. At each scheduled meeting, members of the Committee shall be given the opportunity to discuss any issue on the list or set any such issue aside for further discussion at a subsequent meeting.

# F. Consultation Required In Cases of Immediate Action Affecting the MaineCare Program

# Effective 2/13/11

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79 Last Updated: 2/13/11

# MAINECARE ADVISORY COMMITTEE (cont.)

Effective 2/13/11

1.23

In the event that final or determinative action on a proposal, for which the Director of MaineCare Services has a duty to consult with the MaineCare Advisory Committee pursuant to Section 1.23 but has not yet done so, will occur prior to the next regularly scheduled meeting of the Committee, the Director shall:

- 1. Determine if time permits and if the issue is significant enough to warrant an emergency meeting of the Committee. Any proposal involving reduction in the scope of medical services provided by the program; member cost-sharing; provider fee adjustments; or eligibility for program services shall be considered significant enough to warrant an emergency meeting if time allows;
- 2. If time does not allow for an emergency meeting, the Director shall make every good faith effort to notify the chairperson designated for this purpose, of the pending matter and seek the advice of the Committee before a decision is made;
- 3. In the event that none of the above is possible because of the immediacy of the action, the Director shall notify any members of the Committee who are reasonably available for consultation before the action is taken.

**SECTION 1** 

**GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established: 7/1/79
Last Updated: 2/13/11

#### **APPENDIX #1**

# **CODE OF ETHICS FOR INTERPRETERS\***

The following principles of ethical behavior are affirmed to protect and guide interpreters and transliterators, both for non-English speaking, and for hearing and deaf members. Underlying these principles is the desire to ensure for all the right to communicate.

This Code of Ethics applies to all interpreters and transliterators providing services to MaineCare members and reimbursed by MaineCare.

	Interpreters/transliterators shall keep all assignment-related information strictly confidential.
	Interpreters/transliterators shall render the message faithfully, always conveying the content and spirit of the speaker using language most readily understood by the person(s) whom they serve.
	Interpreters/transliterators shall not counsel, advise or interject personal opinions.
	Interpreters/transliterators shall accept assignments using discretion with regard to skill, setting, and the members involved.
	Interpreters/transliterators shall request compensation for services in a professional and judicious manner.
	Interpreters/transliterators shall function in a manner appropriate to the situation.
	Interpreters/transliterators shall strive to further knowledge and skills through participation in workshops, professional meetings, interaction with professional colleagues, and reading of current literature in the field.
	Interpreters/transliterators shall strive to maintain high professional standards in compliance with the Code of Ethics.
have read, understand and agree to abide by the Code of Ethics as stated above.	
Pri	nted name Written Signature
Date	

<sup>\*</sup> Adapted from the Code of Ethics of the Registry of Interpreters for the Deaf (RID).

SECTION 1 **GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES** Established 7/1/79 Last Updated: 2/13/11

Effective 2/13/11

#### **APPENDIX #2**

# PERTINENT SECTIONS FOR REQUIRED COMPLIANCE UNDER THE FALSE CLAIMS ACT

The False Claims Act (FCA) referenced in 31 U.S.C. §3729 provides in pertinent part:

"Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000 plus three (3) times the amount of damages which the Government sustains because of the act of that person...."

Compliance with Section 6032 (Employee Education about False Claims Recovery) of the Deficit Reduction Act of 2005, is mandatory for providers or provider entities making or receiving payments of at least \$5,000,000 under the MaineCare Program in any federal fiscal year. The \$5,000,000 threshold, for MaineCare purposes, is based upon paid claims or amount of contract, net of any adjustments to those claims or contracts. Those affected providers or provider entities meeting this threshold include the following:

An individual governmental agency, organization, unit, corporation, partnership, individuals, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for profit or not for profit, that receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 during any federal fiscal year (FFY).

- 1. The Maine Department of Health and Human Services (hereinafter "the Department") will monitor compliance with these federal requirements by notifying all entities who met this threshold in the previous federal fiscal year. This notification will be completed in June of each calendar year thereafter. The Department will incorporate into the provider enrollment agreement and any contracts, the responsibilities of the entities in implementing Section 6032 (Employee Education about False Claims Recovery) of the Deficit Reduction Act of 2005.
- 2. The Department will request copies of the affected provider's written policies, including any employee handbooks or instructions, if they exist, and the plan to disseminate those policies to staff.
- 3. The Department will conduct a desk review of the entity's written policies and procedures and provide a written response of approval and/or suggestions to said policies and dissemination plan. Said policies and procedures will include an explanation of the false claims act; the entity's policies and procedures for detecting and preventing waste, fraud and abuse; the rights of the employee to be protected as whistle blowers and telephone numbers and/or addresses for reporting fraud and abuse.

# SECTION 1 GENERAL ADMINISTRATIVE POLICIES AND PROCEDURES Established 7/1/79 Last Updated: 2/13/11

# APPENDIX #2 (cont.)

- 4. Thereafter, the Department will contact entities in June on an annual basis for any update or change to its written policies in order to assure on-going compliance. The Department will accomplish this verification by provider survey.
- 5. Newly identified entities will be required to submit their policies, dissemination plan and any additional information needed by the Department to determine compliance with the requirements referenced in #2, 3 and 4 above.
- 6. The Department has a range of sanctions contained in its administrative regulation for non-compliance with MaineCare policies. These sanctions range from requiring a plan of correction to termination from the MaineCare Program. These sanctions will be applied to non-compliance with the "Employee Education About False Claims Recovery."